

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13380 CERTIFICATE OF DEATH

13312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pines-on-the Severn Rd.</b>				d. STREET ADDRESS <b>Pines-on-the Severn Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John L. Anderton</b>		First	Middle	Last	4. DATE OF DEATH <b>December 11</b>	Month	Day	Year <b>1960</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 5, 1910</b>	9. AGE (In years lost birthday) <b>50 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Anderton</b>				14. MOTHER'S MAIDEN NAME <b>Amada Lockett</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>Mrs Emily I. Anderton Wife</b>		Address <b>Same As # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> INTERVAL BETWEEN ONSET AND DEATH <b>minute -</b>									
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>DUE TO</b>		(b) <b>DUE TO</b>		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>121 CATHEDRAL ST</b>		(County) <b>Annapolis</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>12/11/60</b> , to <b>12/11/60</b> , that I last saw the deceased alive on <b>12/10/60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 CATHEDRAL ST Annapolis, Maryland</b>									
ACTUAL SIGNATURE <b>Richard N. Peeler</b>		DATE SIGNED <b>12/14/60</b>							
PHYSICIAN'S NAME (Type) <b>RICHARD N. PEELER</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-16-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Bluff Cemetery</b>		22d. LOCATION (City, town, or county) <b>Annapolis, Maryland</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hopping</b>		ADDRESS <b>Hopping Funeral Home Annapolis, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - MARYLIFE

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	PLACE	CAUSE OF DEATH	DIAGNOSIS	EXAMINER	RELEASER
John Doe	55	M	1981-01-01	10:00 AM	Hospital	Cardiac Arrest	Heart Disease	Dr. John Smith	John Doe's Son
This certificate is issued under the laws of Maryland.									
I declare that the above information is true to the best of my knowledge and belief.									
Signed: Dr. John Smith									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

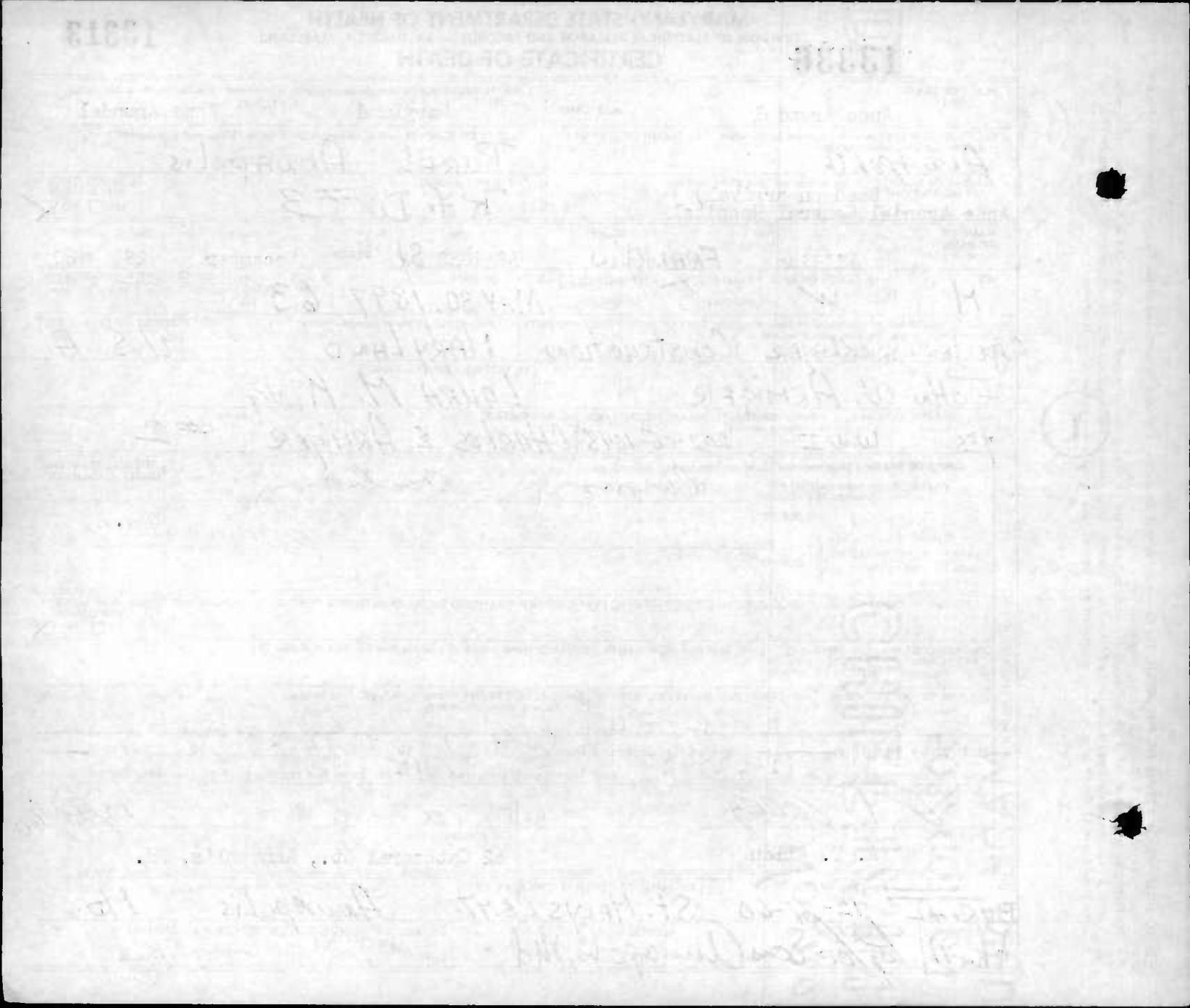
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

13313

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Annapolis</i>										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) <i>Dead on arrival</i> Anne Arundel General Hospital		d. STREET ADDRESS <i>R.F.D. #3</i>										
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) William FRANKLIN		First	Middle									
4. DATE OF DEATH December 28 1960	Lost	Month	Day	Year								
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>MAY 30, 1897</i>	9. AGE (In years last birthday) <i>63</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CARPENTER - BRICKLAYER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						
13. FATHER'S NAME <i>John W. Armiger</i>		14. MOTHER'S MAIDEN NAME <i>Laura M. King</i>		Address <i>#2</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES WWI</i>		16. SOCIAL SECURITY NO. <i>202-06-1048</i>		17. INFORMANT <i>CHARLES E. ARMIGER</i>		INTERVAL BETWEEN ONSET AND DEATH <i>9 mos</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  <i>420.1</i>		DUE TO  <i>Coronary</i>										
Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b)		DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>62 Cathedral St., Annapolis, Md.</i>		20f. (City or town) <i>Annapolis</i>		(County) <i>Md.</i>		(State) <i>Md.</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>July 17 59</i> to <i>12-28-60</i> , 19, that (I) (we) last saw the deceased alive on <i>12-12-69</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above.												
22a. SIGNATURE <i>A. T. Allen</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/29/60</i>					
22c. PHYSICIAN'S NAME (Type) <i>A. T. Allen</i>		22d. ADDRESS <i>62 Cathedral St., Annapolis, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12-31-60</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>St. MARY'S CEMT.</i>		23d. LOCATION (City, town, or county) <i>Annapolis</i>		(State) <i>Md.</i>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor &amp; Sons Annapolis, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>JAN 3 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>						



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13381 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13381

1. PLACE OF DEATH  
a. COUNTY Anne Arundel MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Linthicum

c. LENGTH OF STAY IN lb Few seconds

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Route 8

First Middle Last

Anthony Vincent Bahor

5. SEX M 6. COLOR OR RACE W 7. MARRIED  NEVER MARRIED  b. DATE OF BIRTH 8/29/34

WIDOWED  DIVORCED

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer's aide at Westinghouse

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Pittsburgh, Penn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Michael Bahor

14. MOTHER'S MAIDEN NAME ? unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 167-26-6338 17. INFORMANT Mrs. A. V. Bahor (wife) Address

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (e) Fracture of skull, fracture of left femur  
INTERVAL BETWEEN ONSET AND DEATH Sudden

812 X  
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first.  
(b)  
DUE TO  
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

20a. EXTERNAL CAUSE WAS PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was fixing tire of Route 8 when was hit by another vehicle.

20c. TIME OF INJURY Month, Day, Year 12/13/60 20d. INJURY OCCURRED While at work Not While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 8 20f. (City or town) Linthicum (County) A.A. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL SIGNATURE Gustave H. Faubert, M.D.

EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.

22e. BURIAL, CREMATION, REMOVAL (Specify) Burial Dec 17-60 22b. DATE THEREOF Dec 17-60 22c. NAME OF CEMETERY OR CREMATORY Holly Cross Cemetery 22d. LOCATION (City, town, or county) Belvoir Hwy Brooklyn Md. (State)

23. FUNERAL DIRECTOR Bernard G. Taube ADDRESS Glen Burnie Md.

VS. A15ME 5M 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL CERTIFICATION

## 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE Maryland b. COUNTY Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe

d. STREET ADDRESS 5512 Willys Ave.

4. DATE OF DEATH December 13 19 60

9. AGE (In years less birthday) 26 yrs. IF UNDER 1 YEAR Months Deys IF UNDER 24 HRS. Hours Min.

10. CITIZEN OF WHAT COUNTRY? USA

11. BIRTHPLACE (State or foreign country) Pittsburgh, Penn.

14. MOTHER'S MAIDEN NAME ? unknown

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (e) Fracture of skull, fracture of left femur  
INTERVAL BETWEEN ONSET AND DEATH Sudden

812 X  
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first.  
(b)  
DUE TO  
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was fixing tire of Route 8 when was hit by another vehicle.

20c. TIME OF INJURY Month, Day, Year 12/13/60 20d. INJURY OCCURRED While at work Not While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 8 20f. (City or town) Linthicum (County) A.A. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER  12/12/60 DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county) Glen Burnie, Md.

22e. BURIAL, CREMATION, REMOVAL (Specify) Burial Dec 17-60 22b. DATE THEREOF Dec 17-60 22c. NAME OF CEMETERY OR CREMATORY Holly Cross Cemetery 22d. LOCATION (City, town, or county) Belvoir Hwy Brooklyn Md. (State)

23. FUNERAL DIRECTOR Bernard G. Taube ADDRESS Glen Burnie Md.

VS. A15ME 5M 7/59

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

DATE DEC 16 '60

1000  
БІОАКТОВИЙ ТАКТИЧНИЙ ПЛАН  
ВІДНОСИНАХ МІж СУДОМ І СІРІЮ  
ІТАЛІЯ КО-ЕТАПІХАД СІРІЮ І АДДА  
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MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

13315

13382

## **CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 9 years 1 mos, 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital				e. STREET ADDRESS 845 Pierce Street	
3. NAME OF DECEASED (Type or print)		First Annie	Middle J.	Last Barnes	4. DATE OF DEATH Month 12 Year 30 Year 60 19
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1890?	9. AGE (In years last birthday) yrs. 70?	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Unknown	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  443X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Chronic Brain Syndrome associated with hyper- tensive Cardiovascular Disease  DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Generalized Arteriosclerosis					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on		11/13/61	19 51	12/30	19 60, that (I) (we) last M, from the causes and on the date stated above.
22a. SIGNATURE  <i>L. Benedict</i>		M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/> 12/30/1960 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF 5-1-61	23c. NAME OF CEMETERY OR CREMATORIAL university, md,		23d. LOCATION (City, town, or county) Baltimore, md (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Reese mortuary		ADDRESS Anna, md	25a. REC'D BY REGISTRAR MAR 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krause

1961

ДАВИД САУЗА  
ДАВИД САУЗА

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Іванка зуп. відповідь

Іванка зуп. відповідь

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Іванка зуп. відповідь

09

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

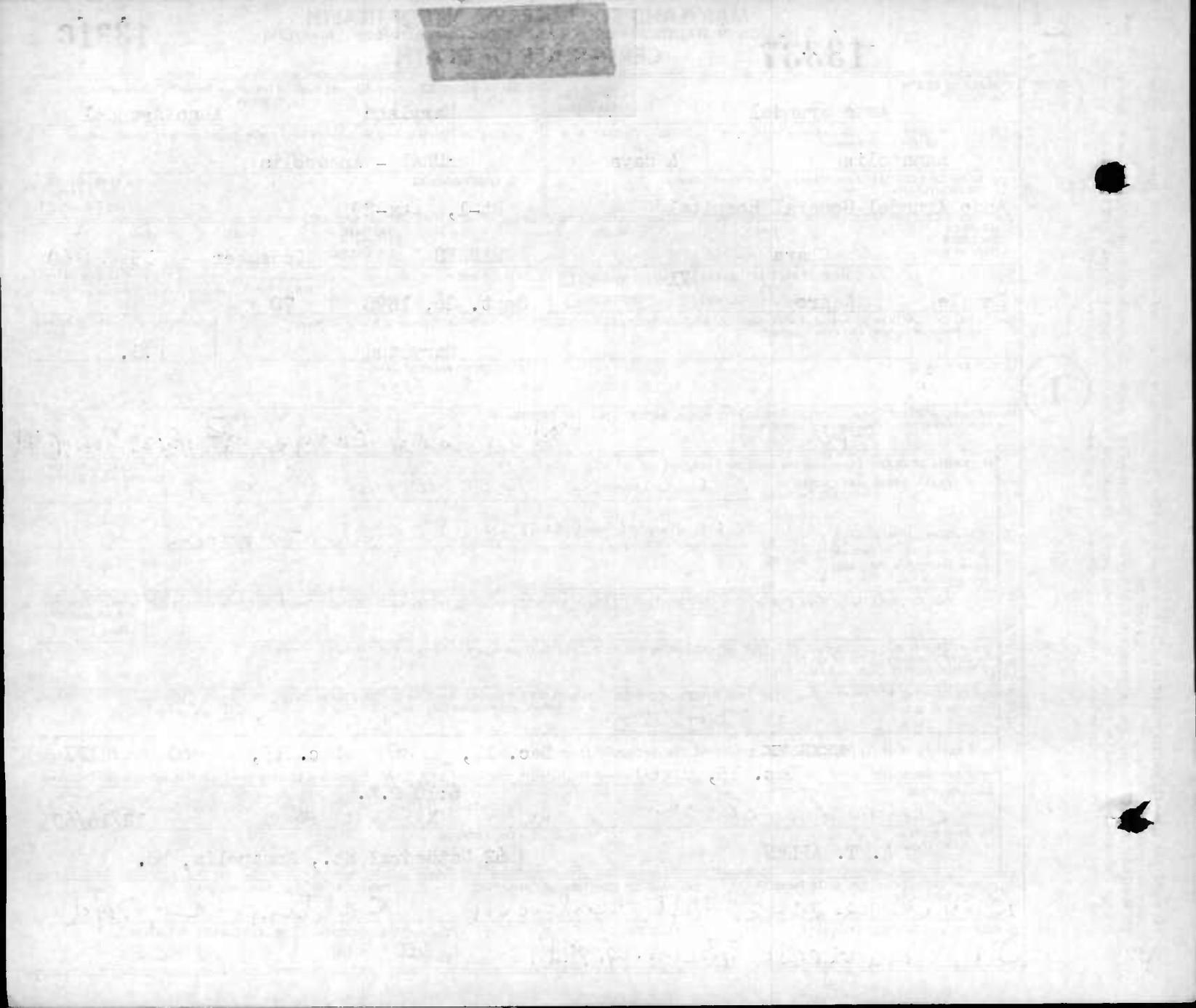
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13316

13337

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Anne Arundel MARYLAND		a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	c. LENGTH OF STAY IN 1b <b>4 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>Rt-1, Box-29</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Clara</b>	Middle <b></b>	Last <b>BARNES</b>
4. DATE OF DEATH	Month <b>December</b>	Day <b>15</b>	Year <b>1960</b>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 26, 1890
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months <b>70</b>	11. IF UNDER 24 HRS. Months <b>yrs.</b>	12. IF UNDER 24 HRS. Days <b>Hours</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	Harrison Barnes - Pt. 1B-629 Annap. Md.		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
260 X	DUE TO	Nexema Pulmonary Edema	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)	uncontrolled Dusots, Gorgone	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month Day Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19		Annapolis	
21. I certify that (I) attended the deceased from Dec. 11, 1960, to Dec. 15, 1960, that (I) last saw the deceased alive on Dec. 15, 1960, and that death occurred at M, from the causes and on the date stated above.	6:10 P.M.		
22a. SIGNATURE	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/16/60</b>
22c. PHYSICIAN'S NAME (Type)	A. T. ALLEN		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town, or county) (State)
Burial 12-20-60	mt. Auburn		Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William Reese, Jr. Annap. Md.		DEC 19 '60	Civins S. Thorne



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13353

## CERTIFICATE OF DEATH

13317

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Herondale</b>		d. STREET ADDRESS <b>1801 Matravers Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USNH, ANNAPOLIS, MARYLAND</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>BILLINGS</b>	Middle <b>Alfred</b>	Last <b>Isadore</b>	4. DATE OF DEATH Month <b>December</b>	Day <b>25</b>	Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-93</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USN (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Abraham Issac BILLINGS</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Ida LANGLOIS</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WWI and II</b>		17. INFORMANT Address <b>Wife - 1801 Matravers Road, Herondale, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b>								
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? _____ YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>8-16-60</b> , 19_____, to <b>12-25-60</b> , 19_____, that I last saw the deceased alive on <b>12-25-60</b> , 19_____, and that death occurred at <b>7:35A M</b> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>ADDRESS</b> DATE SIGNED <b>12-25-60</b>								
ACTUAL SIGNATURE <b>E.C. Keene</b> M.D.								
PHYSICIAN'S NAME (Type) <b>E. C. KEENE, LT MC USNR</b>								
22a. BURIAL / CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 28-60</b>		22c. NAME OF CEMETERY OR CEMATORIUM <b>Holy Cross Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arbry Pa</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Benard Funk</b>		ADDRESS <b>Glen Burn Rd</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		

## CERTIFICATE OF DRAFT

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000
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FOR STATE  
HEALTH DEPT.

necessary,  
Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral  
director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained  
in our files.



TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in our files.

TO BURIAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
1338 MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)												
a. COUNTY Anne Arundel			e. STATE Same b. COUNTY Same												
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Linthicum			c. LENGTH OF STAY IN 1b 1 year												
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) King Brook Rd.			d. STREET ADDRESS Sa me												
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			
Leonard Joseph Blanchfield												December 29 1960			
5. SEX			6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M			W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7/3/22		38 yrs.			Months		Days	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?						
Stationary Engineer at the Container Corp.						Baltimore, Md.			USA						
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME												
John Blanchfield			Mary Shiroky												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address						
Yes			WWTI			215-14-0936			Mrs. Dorothy Blanchfield (wife)						
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)			Stangulation (self) by tying a clothes line around Sudden												
974X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause (b),			DUE TO his neck.												
{			(b)												
DUE TO															
{			(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)															
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:30 P.M. 12/29/60			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			20f. (City or town) Linthicum, Md.			(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> Gustave H. Faubert, M.D.												
22e. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF 1/2/1961			22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			22d. LOCATION (City, town, or county) Baltimore, Maryland			(State)			
Burial						Baltimore National Cem.									
23. FUNERAL DIRECTOR			24e. REC'D BY REGISTRAR JAN 3 '61									24b. REGISTRAR'S SIGNATURE			
Howard H. Hubbard 4107 Wilkens Ave.												Arthur S. Kraus			
VS. A15ME 5M 7/59			DATE												
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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 13384 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13319

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

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2  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Meade</b>		b. COUNTY <b>Anne Arundel</b>	
c. LENGTH OF STAY IN lb <b>Few seconds</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessups</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Fort Meade Hospital</b>		d. STREET ADDRESS <b>Route 2</b>	
3. NAME OF DECEASED (Type or print) <b>GLENN</b>		First	Middle
		Last	
4. DATE OF DEATH <b>December 4, 1960</b>		Month	Day
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/21/60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seattle, Washington</b>	
11. BIRTHPLACE (State or foreign country) <b>Seattle, Washington</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elbert Bland</b>		14. MOTHER'S MAIDEN NAME <b>Lucile Bunting</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or date of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The parents</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis</b>			
INTERVAL BETWEEN ONSET AND DEATH			
492X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S. Fisher</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		DATE SIGNED <b>12/5/60</b>	
Address (Street, city, town, or county) <b>Seattle, Washington</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>12-8-60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Evergreen Cemetery</b>
		ADDRESS	22d. LOCATION (City, town, or country) (State) <b>Seattle, Washington</b>
23. FUNERAL DIRECTOR <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE DEC 9 '60	24b. REGISTRAR'S SIGNATURE <i>Russell S. Fisher</i>

VS. A15ME  
5M 7/59

Moore



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13338

## CERTIFICATE OF DEATH

13320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. LENGTH OF STAY IN lb <i>15</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1128 Tyler Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Mary Frances Boettcher</i>		First	Middle						
		Last	4. DATE OF DEATH <i>12-23 1960</i>						
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						
		8. DATE OF BIRTH <i>Aug 16<sup>th</sup> 1904</i>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>							
10c. BIRTHPLACE (State or foreign country) <i>Sandy Hook N.J.</i>		11. CITIZEN OF WHAT COUNTRY? <i>N. S A</i>							
13. FATHER'S NAME <i>Griffith H. Thomasson</i>		14. MOTHER'S MAIDEN NAME <i>Sallie Lou King</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>- - - - -</i>							
17. INFORMANT <i>J. Earle Boettcher</i>		Address <i>2</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>154 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>(c)</i>									
INTERVAL BETWEEN ONSET AND DEATH <i>11 mos.</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		Month <i>Jan</i>	Day <i>23</i>	Year <i>1960</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Annapolis</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Jan 23, 1960</i> , to <i>Dec 23, 1960</i> , that I last saw the deceased alive on <i>Dec 23, 1960</i> , and that death occurred at <i>Annapolis</i> M.D., from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>Annapolis</i> M.D.									
ACTUAL SIGNATURE <i>E. Linhardt</i> DATE SIGNED <i>12/28/60</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-26-1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Bluff Cemt</i>		22d. LOCATION (City, town, or county) <i>Annapolis</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md</i>		ADDRESS <i>1128 Tyler Ave</i>		24a. REGD. BY REGISTRAR <i>DEC 28 1960</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										13321			
13339					CERTIFICATE OF DEATH								
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL - Lothian</b>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>					d. STREET ADDRESS <b>Brookwoods Road</b>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Ellen</b>		Middle <b>NORA</b>		Last <b>BRADY</b>		4. DATE OF DEATH <b>December</b>		Month <b>13</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b>		8. DATE OF BIRTH <b>Sept. 14, 1883</b>		9. AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR Months <b>77</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Tenant</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>----- Hooper</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>- - - - -</b>		17. INFORMANT <b>Mrs. Wallace McKenzie-Lothian, Md.</b>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacterial pneumonia</b> 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral vascular accident</b> (c) <b>Diabetes mellitus</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) <b>(Physician)</b> attended the deceased from <b>Aug. 1960</b> to <b>Dec. 12, 1960</b> , that (I) <b>(Physician)</b> last saw the deceased alive on <b>Dec. 12, 1960</b> , and that death occurred at <b>3:55 A.M.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Emily H. Wilson</b>					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/13/60</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. Emily H. Wilson</b>					22d. ADDRESS <b>Lothian, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/17/60</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Trinity Cemetery</b>			23d. LOCATION (City, town, or county) <b>Upper Marlboro, Md.</b>				(State)		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Marlboro, Md.</b>					ADDRESS					25a. REC'D BY REGISTRAR DATE <b>DEC 20 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

2

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove [redacted] from papers. Pages 1 and 2 [redacted] and be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										13322			
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>					b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>1 day</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Harwood</b>					d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>										e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Peggy</b>		Middle <b>Irene</b>		Last <b>BRADY</b>		4. DATE OF DEATH <b>December</b>		Month	Day	Year	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>December 19, 1960</b>			9. AGE (In years lost birthday) yrs. <b>22</b>		IF UNDER 1 YEAR Months <b>22</b>		IF UNDER 24 HRS. Hours <b>22</b>		Min. <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Joseph Basil BRADY</b>					14. MOTHER'S MAIDEN NAME <b>Dorothy Christine CLARKE</b>					Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]					16. SOCIAL SECURITY NO.			17. INFORMANT		Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Prematurity</i>										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
<b>Dec. 19, 1960</b>		<b>19</b>											
21. I certify that (I) <b>Clayton Norton</b> attended the deceased from <b>Dec. 19, 1960</b> to <b>Dec. 20, 1960</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>Dec. 20, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.													
22a. SIGNATURE <i>Clayton Norton</i>		M.D.		ATTENDING PHYS. <input type="checkbox"/>		3:00 P.M.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/22/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clayton Norton</b>		22d. ADDRESS <b>Medical Building, Severna Park, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 23, 1960</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt Zion</b>		23d. LOCATION (City, town, or county) <b>Lothian, Maryland</b>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Brian E. Hagerty</i>		ADDRESS <b>Hopping Funeral Home Annapolis, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 27 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>							
2063325XVO													

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13383

## CERTIFICATE OF DEATH

13323

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF ILLNESS IN 1b <b>27 years 9 mos. 22 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Thaddeus</b>	Middle <b>Brice</b>	4. DATE OF DEATH Month <b>12</b> Year <b>28</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/15/1888</b>
9. AGE (In years at time of death) <b>107</b>	10. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Samuel Brice</b>	14. MOTHER'S MAIDEN NAME <b>Sallie ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Hospital Records</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Chronic Brain Syndrome associated with Cerebral and Generalized Arteriosclerosis (c) DUE TO			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>General Paresis</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		
20c. TIME OF INJURY Month, Day, Year Hour <b>12</b> , Min. <b>00</b> , AM p. m. <b>19</b>	20d. INJURY OCCURRED While <b>not white</b> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office etc.) <b>bldg.</b>	20f. (City or town) <b>Baltimore</b> (County) <b>Md.</b> (State) <b>Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>12/28/60</b> , and that death occurred at <b>12/28/60</b> , at <b>9:25 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict, M. D.</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>Dec. 28, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>	22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>12/29/60 mt Auburn</b>	23b. DATE THEREOF <b>12/29/60</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>mt Auburn</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <i>George M. Nelson</i>	ADDRESS <b>1348 N Calhoun St</b>	25a. REC'D BY REGISTRAR DATE <b>JAN 3 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

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seen

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but not

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seen

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seen (part)

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seen

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shrub willow

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stems of Salix fragilis, but also on S. alba

shrub willow

seen

but not seen (part)

seen (part)

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the registrar prior to burial or removal.

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2  
VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1334 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13324

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE			
<i>Annapolis</i>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
<i>Annapolis</i>		<i>Annapolis</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS			
<i>202 Prince George St.</i>		<i>202 Prince George St.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle		
<i>Jean</i>		<i>Andrews</i>	<i>Champion</i>		
3. NAME OF DECEASED (Type or print)	Last	4. DATE OF DEATH	Month	Day	Year
<i>Jean</i>	<i>Champion</i>	<i>Aug 22<sup>d</sup> 1960</i>	<i>12</i>	<i>18</i>	<i>1960</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1YEAR Months Days Hours Min.
<i>Female</i>	<i>White</i>	<i>House</i>	<i>Aug 22<sup>d</sup> 1900</i>	<i>60</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Nostress</i>		<i>Hammon Harwood House</i>		<i>San Francisco Cal</i>	
12. CITIZEN OF WHAT COUNTRY?					
<i>U. S. A</i>					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
<i>Philip Andrews</i>		<i>Clara Fuller</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				<i>E.C. Champion</i> 939 Hickcrosst Circle Oakland Cal.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Hypertension Cardiosascular disease</i>			
443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		<i>Indirect cause</i>			
(b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Nutrol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>E.C. Champion</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <i>12/18/60</i>
EXAMINER'S NAME (Type) <i>E. L. Bryant Jr.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 23-1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i>	22d. LOCATION (City, town, or county) <i>Arlington</i>	(State) <i>Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md.</i>	ADDRESS <i>John M. Taylor Sons Annapolis Md.</i>	24a. REC'D BY REGISTRAR <i>DEC 23 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

DEPARTMENT OF PUBLIC SAFETY - STATE OF GEORGIA  
EXCELSIOR EXTRAVAGANZA DEATH

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be repaired by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 [redacted] be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13325

13386

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>10 15 yrs mos 24 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Harry</b>	Middle	Last <b>Chester</b>
4. DATE OF DEATH	Month <b>12</b>	Day <b>6</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1896</b>
9. AGE (In years last birthday) <b>64 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	12. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Tom Chester</b>	14. MOTHER'S MAIDEN NAME <b>Laura Grant</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Hospital Records</b>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b>			
DUE TO <b>Decompensatory Heart Disease</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b>			
DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Hour o. m. ----- p. m. -----	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 12, 1945, to Dec. 6, 1960, that (I) (we) last saw the deceased alive on Dec. 6, 1960, and that death occurred at 6 AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>DeLeonard</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE <b>December 6, 1960</b>
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-9-60</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Glorius</b>	23d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. Williams</i>	24b. ADDRESS <b>322</b>	25a. REC'D BY REGISTRAR DATE <b>REC 9 '60</b>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knue</i>

1981

FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your office.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13342 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13326

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>2802 Delaware Avenue</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>HOWARD</b>	Middle <b>M.</b>	Last <b>COCKERELL</b>	4. DATE OF DEATH <b>December 12 1960</b>	Month <b>December</b>	Day <b>12</b>	Year <b>1960</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1909</b>	9. AGE (In years from birthday) <b>51</b>	IF UNDER 1 YEAR <b>Months</b>	IF UNDER 24 HRS. <b>Days</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Upholsterer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stewart &amp; Co.</b>		11. BIRTHPLACE (State or foreign country) <b>W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>John E. Cockerill</b>		14. MOTHER'S MAIDEN NAME <b>Alice Pritchard</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Edgar P. Cockerill - 2802 Delaware Avenue</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20e. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Boat sunk.</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>12/12</b> p.m. <b>1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chesapeake Bay</b>	20f. (City or town) <b>Off Annapolis</b>	(County) <b>A.A.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Charles S. Petty</b> EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b> Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/16/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Meadowridge Mem. Park</b>		22d. LOCATION (City, town, or country) (State) <b>Elkridge, Maryland</b>			
23. FUNERAL DIRECTOR <b>Han J. Pickner &amp; Sons Inc</b>		ADDRESS <b>Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>✓</b>			

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be required by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13387

13327

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>6 yrs 4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1114 Pennsylvania Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Louise</b>	Middle <b></b>	Last <b>Cole</b>	4. DATE OF DEATH <b>1883 ?</b>	Month <b>12</b>	Day <b>27</b>	Year <b>1960</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1883 ?</b>	9. AGE (In years lost birthday) yrs. <b>77?</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	Days <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Atison Cole</b>				14. MOTHER'S MAIDEN NAME <b>Lucy ?</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Hospital Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Chronic Brain Syndrome associated with General Arteriosclerosis</b> (c) DUE TO <b></b>								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>								
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>-----</b> 19 p. m. <b>-----</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		
20f. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b>								
21. I certify that (I) (this hospital) attended the deceased from <b>12/23</b> 19 <b>54</b> , to <b>12/27</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12/27</b> 19 <b>60</b> , and that death occurred at <b>7:45</b> , from the causes and on the date stated above.								
22a. SIGNATURE <b>L. Benedict</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Dec. 27, 1960</b>		
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>				22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/31/60</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>Cedar Hill, Md.</b> (State) <b>-----</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. O. Wilson</b>				ADDRESS <b>1000 Maryland Ave.</b>		25a. REC'D BY REGISTRAR DATE JAN 3 '61		25b. REGISTRAR'S SIGNATURE <b>Archibald K. Knapp</b>

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Scutellaria

1  
FOR STATE  
HEALTH DEPT.  
1/13/61 a.m.s  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13329

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendship</b>		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendship</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		4. DATE OF DEATH <b>December / November / 30, 1960</b>		Day 1 Year 1960		
3. NAME OF DECEASED (Type or print) <b>Gail Louise Creek</b>		First	Middle	Last	B. DATE OF BIRTH <b>Nov. 30, 1960</b>	5. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months Days <b>1</b>	IF UNDER 24 HRS. Hours Min. <b>1</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Friendship, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)								
13. FATHER'S NAME <b>Charles Creek</b>		14. MOTHER'S MAIDEN NAME <b>Martha Jones</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.0</b> <b>XOUKDOX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Intra-uterine Anoxia						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Charles S. Petty</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>12/2/60</b>
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>12-6-60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>City Morgue</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md</b>		(State)
23. FUNERAL DIRECTOR <b>VS. A15ME</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Moore</b>		

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803-82

—> 17 —

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 13389

## CERTIFICATE OF DEATH

13330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>	
d. NAME OF HOSPITAL, INSTITUTION, ETC., WHERE DECEASED LAST LIVED <b>District Training School Children's Center</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Veronica</b>		First <b>Veronica</b>	Middle <b></b>
4. DATE OF DEATH <b>Darden</b>		Month <b>December</b>	Day <b>27</b>
5. SEX <b>female</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>July 9, 1950</b>		9. AGE (In years last birthday) <b>10 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutionalized</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (State or foreign country) <b>D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Lee Darden</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Children's Center, Laurel, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  25/X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. DUE TO (b) Severe spastic quadriplegia		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c) Convulsive disorder			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  Severe mental retardation		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/11/52</b> , 19, to <b>December 27, 1960</b> , that I last saw the deceased alive on <b>12/26/60</b> , 19, and that death occurred at <b>12.30M</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Children's Center, Laurel, Md.</b>	
ACTUAL SIGNATURE <i>James E. Boyland</i>		DATE SIGNED <b>12/27/60</b>	
PHYSICIAN'S NAME (Type) <b>James E. Boyland, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>Dec 30, 1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>District Training School</b>	22d. LOCATION (City, town, or county) <b>Laurel</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Delester, ass't dir. D.T.S.</i>		24a. REC'D BY REGISTRAR DATE <b>JAN 4 '61</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>

100

14  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13390 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13331

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ferndale</i>		c. LENGTH OF STAY IN lb <i>81 years</i>		a. STATE <i>Same</i>		b. COUNTY <i>Same</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Same</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>103 Glenmount Avenue</i>		e. STREET ADDRESS <i>Same</i>		d. STREET ADDRESS <i>Same</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Richard Dorsey Davis</i>		First	Middle	Last	4. DATE OF DEATH <i>December 14 1960</i>	Month	Day	Year					
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/4/11</i>	9. AGE (In years last birthday) <i>49 yrs.</i>	IF UNDER 1 YEAR <i>Months</i>	Days	Hours	IF UNDER 24 HRS. <i>Min.</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk and Buyer at L.A.Benson Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Richard D. Davis Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Iola Marie Norrie</i>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-05-9845</i>		17. INFORMANT <i>Mrs. R.D. Davis (wife)</i>		Address <i>108 Glenmount av</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>163X</i>		Cancer of lungs											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b) (c)													
DUE TO  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Gustave H Faubert M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <i>12/15/60</i>					
EXAMINER'S NAME (Type) <i>Gustave H. Faubert M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Dec 19-60</i>		22b. DATE THEREOF <i>Dec 19-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Sixton Pt Cemetery</i>		22d. LOCATION (City, town, or county) <i>Fredrick Rd Baltimore Md</i>							
23. FUNERAL DIRECTOR <i>Bernard A. Kuhn</i>		ADDRESS <i>Glen Burnie Md</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							
VS. A15ME 5M 7/59		DATE DEC 19 '60											



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by our office.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13343 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13352

1. PLACE OF DEATH  
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Battery & Annaode Rd 7urek

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

ROBERT

H.

DEFRANCESCO

December

4, 1960

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED  NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

8/17/21

9. AGE (In years  
last birthday)

39 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Service Man

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Army

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

Pennsylvania

13. FATHER'S NAME

deceased (unknown)

14. MOTHER'S MAIDEN NAME

Mary McFrancisco (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give record date of service)

yes active now

16. SOCIAL SECURITY NO.

171-03-3350

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Multiple crushing injuries of abdomen, chest and head

INTERVAL BETWEEN  
ONSET AND DEATH

812X

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

(b)

DUE TO

(c)

PARTIAL

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Pedestrian struck by auto

20c. TIME OF INJURY Month, Day, Year  
Hour  7:00 p.m. 12/4/1960

20d. INJURY OCCURRED While Not While  
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)  
Road PARTIAL

20f. (City or town) (County) (State)

Anne Arundel, Md.

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE

Russell S. Fisher

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED  
12/5/60

EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

J.H. Bonin & Son

22d. LOCATION (City, town, or country) (State)

Hazleton, Penn.

23. FUNERAL DIRECTOR

ADDRESS

Carl P. Wolverton Funeral Home, Inc.

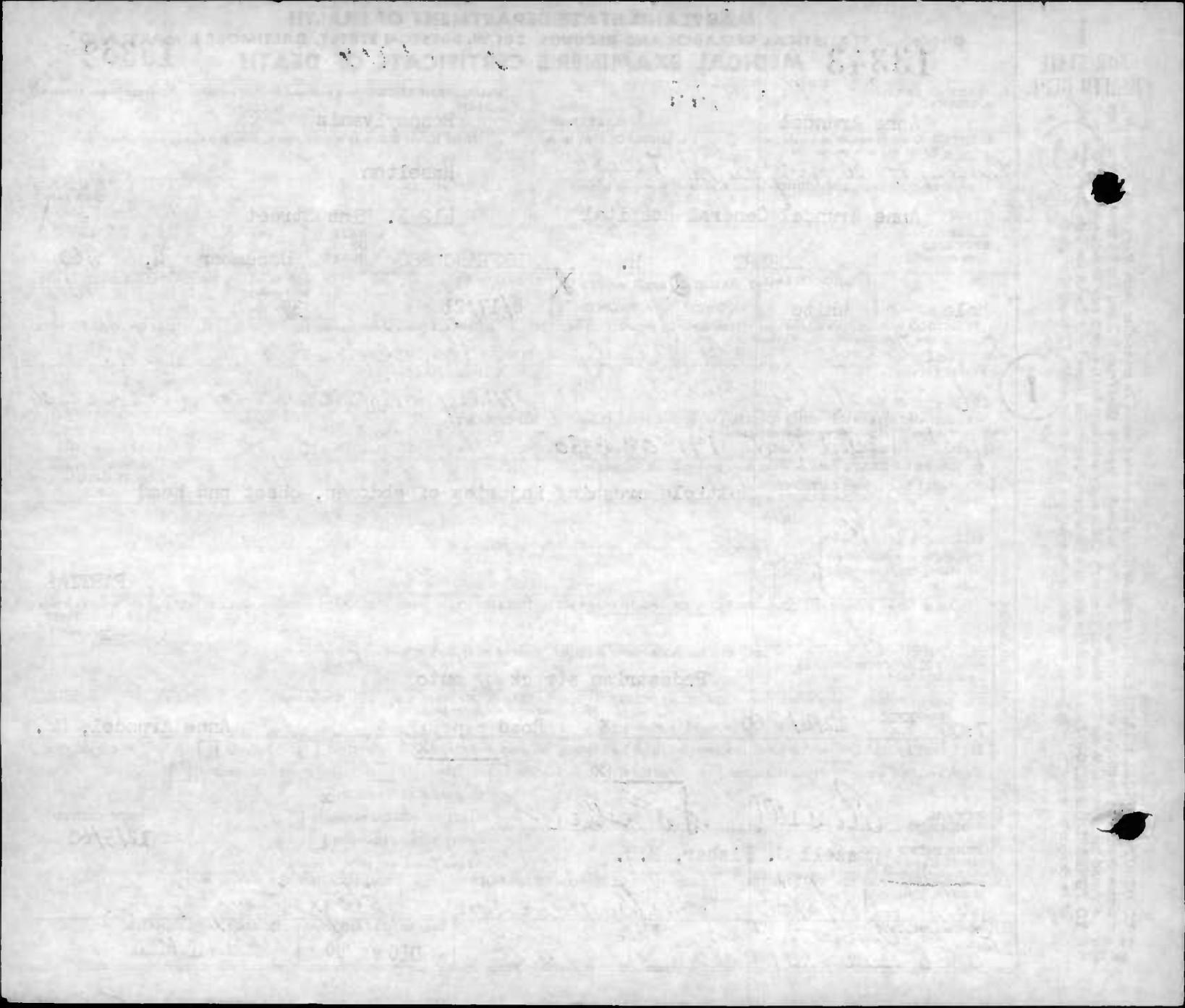
6306-B Belair Rd, Baltimore 6, Md.

24a. REC'D BY REGISTRAR

DEC 9 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause



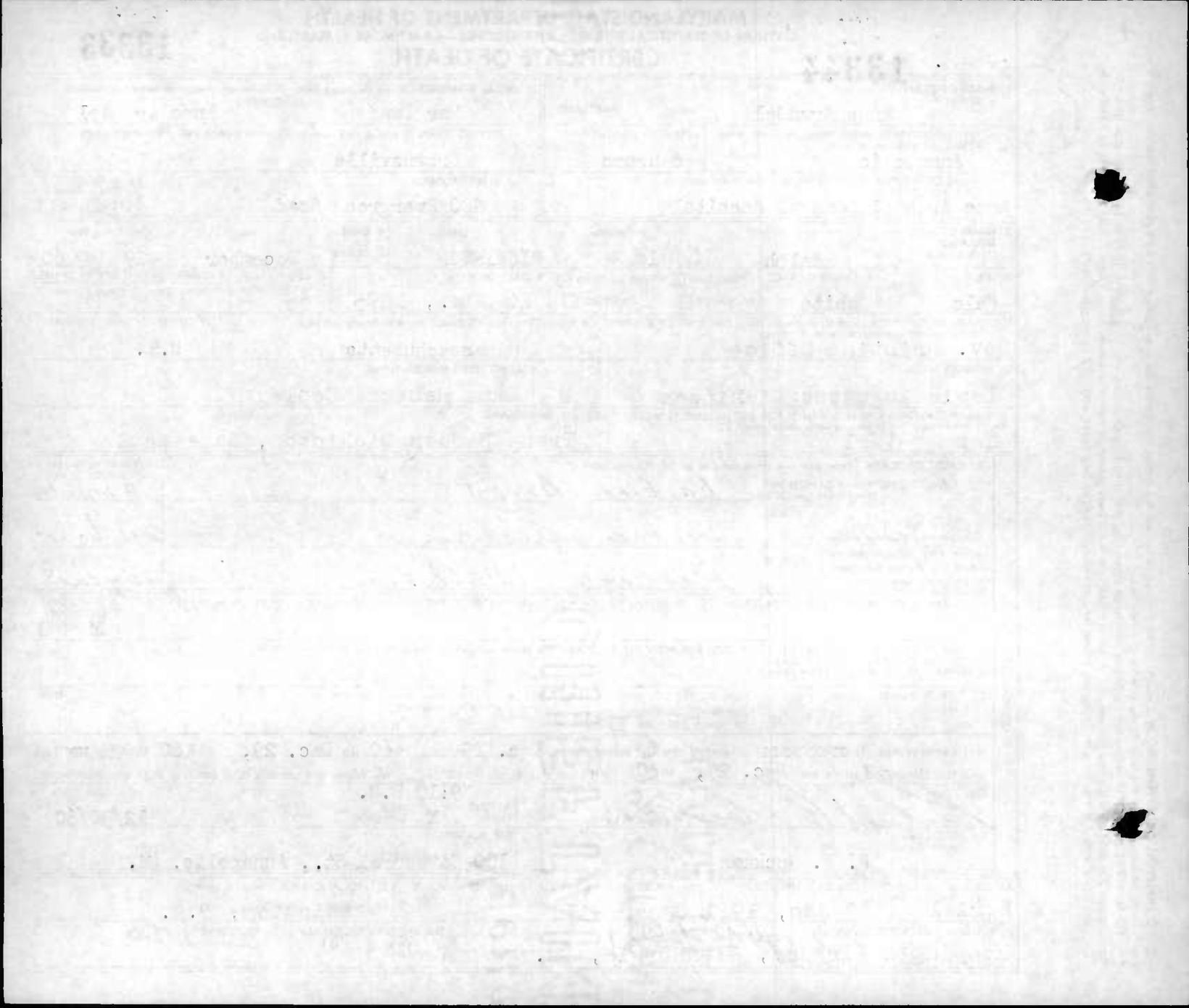
**NO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by [REDACTED] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1333

1334

1. PLACE OF DEATH a. COUNTY  Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Annapolis		c. LENGTH OF STAY IN lb  6 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Crownsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  Anne Arundel General Hospital				d. STREET ADDRESS  880 Evergreen Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First  Ralph	Middle  Louis	Last  DICKINSON	4. DATE OF DEATH  December 29	Month  19 60	Day  Year
S. SEX  Male	6. COLOR OR RACE  White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH  16 Jan., 1895	9. AGE (In years last birthday)  65 yrs.	IF UNDER 1 YEAR  Months  Days	IF UNDER 24 HRS.  Hours  Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Gov. Printing Office		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)  Massachusetts		12. CITIZEN OF WHAT COUNTRY?  U.S.	
13. FATHER'S NAME  Lewis Augustus Dickinson				14. MOTHER'S MAIDEN NAME  Emma Rebecca Cooley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  Yes		16. SOCIAL SECURITY NO.  WWI		17. INFORMANT  Irena Barden Dickinson, Same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  260X Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  DUE TO (b) Diabetic Acidosis DUE TO (c) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 2 minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)  Cathedral St., Annapolis, Md.	(County) (State)
21. I certify that (I) <del>John Hockman</del> attended the deceased from Dec. 29, 1960, to Dec. 29, 1960, that (I) <del>John Hockman</del> last saw the deceased alive on Dec. 29, 1960, and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE  <i>Rachael P. Hockman</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/30/60		
22c. PHYSICIAN'S NAME (Type)  R. I. Hockman				22d. ADDRESS  100 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)  Burial		23b. DATE THEREOF  3 Jan, 1961		23c. NAME OF CEMETERY OR CREMATORIUM  Cedar Hill		23d. LOCATION (City, town, or county)  Washington, D.C. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE  Hopping & Kirkley, Glen Burnie, Md.				25a. REC'D BY REGISTRAR  JAN 4 '61		25b. REGISTRAR'S SIGNATURE  <i>Charles S. Hockman</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by you, it will be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13334

CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hanover</b>		c. LENGTH OF STAY IN 1b <b>12 yrs.</b>		b. COUNTY <b>Anne Arundel</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 121 Rt. 1 Ridge Road</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Hanover</b>	
3. NAME OF DECEASED (Type or print) <b>EVA</b>		First <b>C.</b>	Middle <b>DUCKWORTH</b>	4. DATE OF DEATH <b>December 22, 1960</b>	Month Day Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>17th Nov. '72</b>	9. AGE (In years last birthday) yrs. <b>88</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Garrett Co., Maryland</b>	
13. FATHER'S NAME <b>Jesse D. Fazenbaker</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ormond</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>111-11-1111</b>		17. INFORMANT <b>Mrs. Margaret E. Matthews</b> Address <b>Same As #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>					
<b>782-4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>p. m.</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 1952</b> to <b>December 1961</b> , that (I) (we) last saw the deceased alive on <b>December 1960</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Charles R. Macdonald MD</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Glen Burnie Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>21 st. Dec. '60</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Philos Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Westernport, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. D. King</b>		ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 21 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>

10561

Leavenworth

FOR STATE  
HEALTH DEPT.

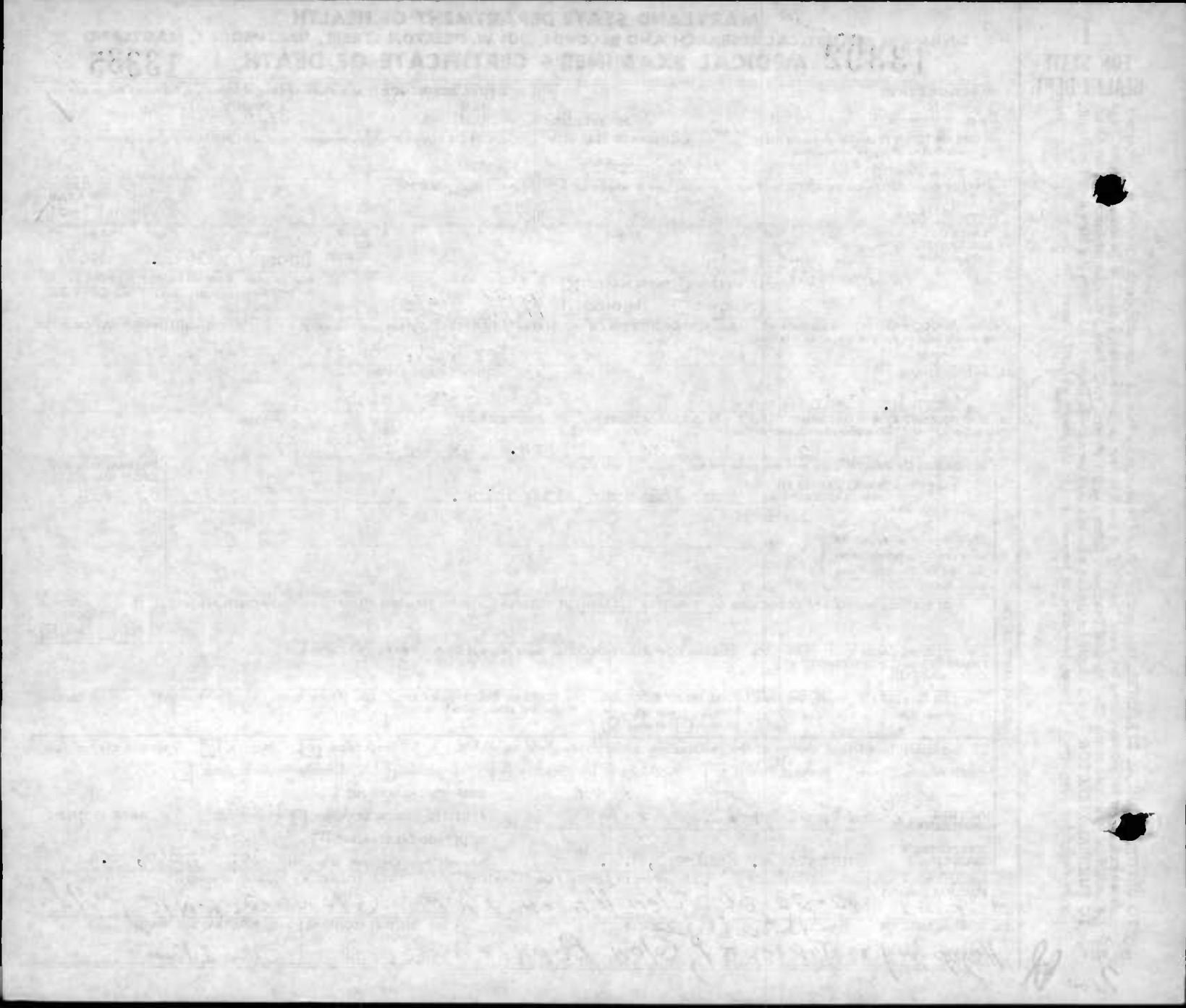
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13392 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13335

1. PLACE OF DEATH e. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE <b>Same</b> b. COUNTY <b>Same</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>		c. LENGTH OF STAY IN lb <b>2 1/2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Same</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Lake Shore</b>		d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Glen Ward Elgin</b>		First	Middle	Last	4. DATE OF DEATH December 19th.	Month	Dey	Year	1960		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>12/19 8/5/60</b>	9. AGE (In years last birthday) yrs. <b>4</b>	IF UNDER 1 YEAR Months <b>4</b>	IF UNDER 24 HRS. Days <b>14</b>	Hours <b>14</b>	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Key West, Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Jimmy D. Elgin</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Smith</b>						Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Jimmy Elgin (mother)</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acut pulmonary infection.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>527.2</b> DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
20c. TIME OF INJURY Hour a.m. p.m.	Month, Dey, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
ACTUAL SIGNATURE: <b>Gustave H. Faubert, M.D.</b>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 12/19/60 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>Glen Burnie, Md.</b>	
EXAMINER'S NAME (Type)		22e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burnie</b> 12-28-60 22b. DATE THEREOF <b>Glen Haven Mem.</b> 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Glen Burnie, Md.</b>								22d. LOCATION (City, town, or country) (State) <b>Glen Burnie, Md.</b>	
23. FUNERAL DIRECTOR <b>Hopking &amp; McLELLAN, Glen Burnie</b>		24e. REC'D BY REGISTRAR <b>DEC 23 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>									



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13394

## CERTIFICATE OF DEATH

13336

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie (Ferndale)</i>		c. LENGTH OF STAY IN lb <i>yrs -</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie (Ferndale) 60</i>		d. STREET ADDRESS <i>509 Old Annapolis Rd.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>509 Old Annapolis Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Marian</i>		First	Middle	Last	4. DATE OF DEATH <i>Fink</i>	Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>29<sup>th</sup> Aug 1898</i>	9. AGE (In years lost birthday) <i>82 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Charles Turner</i>		14. MOTHER'S MAIDEN NAME <i>Ellen (unknown)</i>		INFORMANT <i>Elmer F. fink</i>		Address <i>Same As #2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  Coronary Thrombosis Cardiac Insufficiency									
INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>12-15, 1960</i>	(County) <i>12-16, 1960</i>	(State) <i>Baltimore, Md.</i>			
21. I certify that I attended the deceased from <i>12-15, 1960</i> , to <i>12-16, 1960</i> , that I last saw the deceased alive on <i>12-15, 1960</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Eugene Schnitzer</i> M.D. <i>12-16-60</i>									
DATE SIGNED									
ACTUAL SIGNATURE <i>Eugene Schnitzer</i>									
PHYSICIAN'S NAME (Type) <i>Eugene Schnitzer</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>							
22b. DATE THEREOF <i>20<sup>th</sup> Dec. 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Cross Cemetery</i>		22d. LOCATION (City, town, or county) <i>Brewyn RFD, Md.</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.V. Singlet</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 22 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Cuthbert S. Thomas</i>			

11.10.1910 - 1910-1911  
1910-1911

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

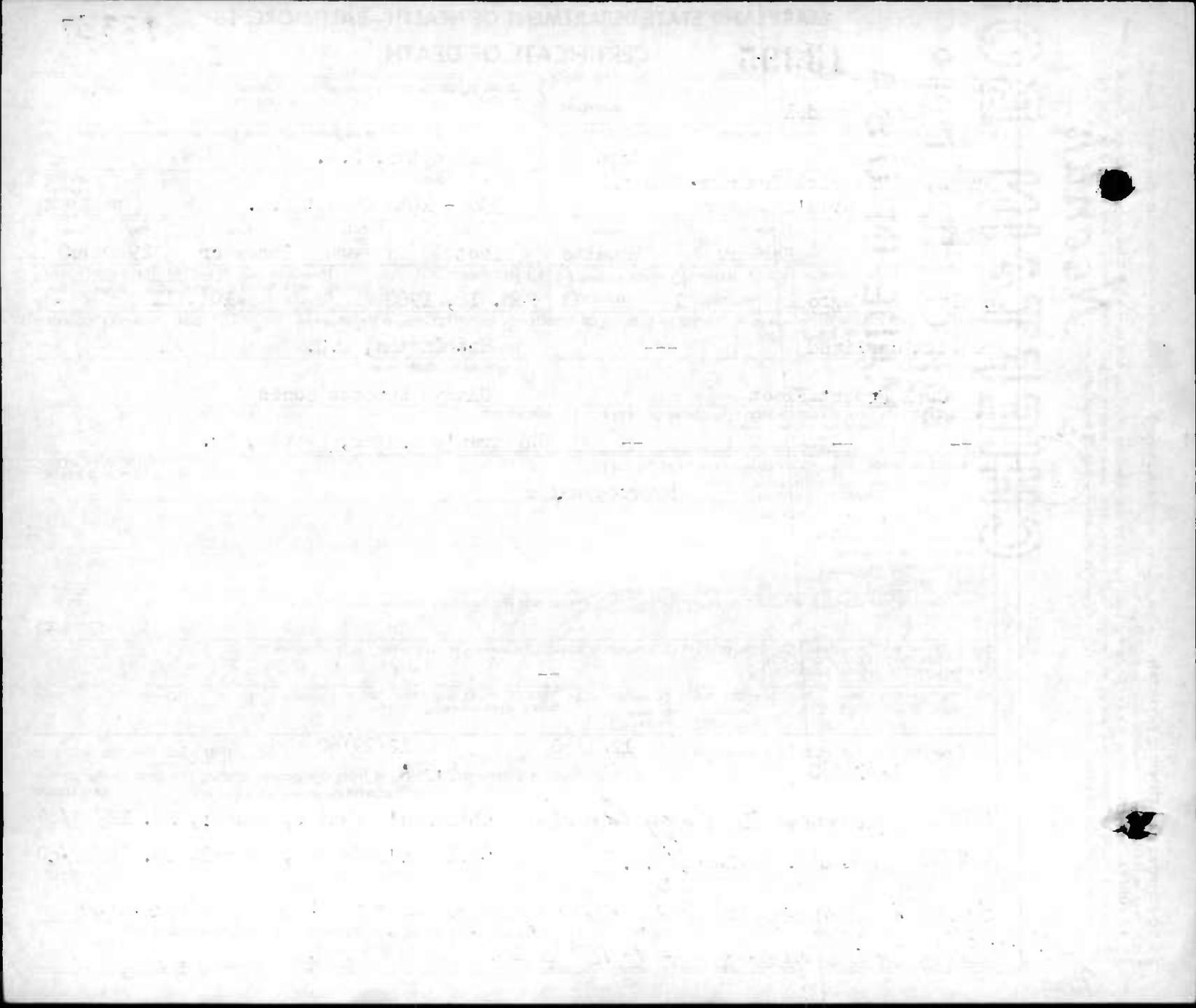
# 13395

## CERTIFICATE OF DEATH

Reg. Dist. No.

13337

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN lb <b>28 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>		d. STREET ADDRESS <b>330 - 16th Street S.E.</b>	
d. NAME OF HOSPITAL OR INSTITUTION <b>District Training School Children's Center</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Barbara</b>	Middle <b>Venette</b>	Last <b>Fleet</b>	4. DATE OF DEATH	Month <b>December</b>	Day <b>29</b>	Year <b>1960</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1960</b>		9. AGE (In years lost birthday) yrs. <b>10</b>	IF UNDER 1 YEAR Months <b>11</b>	IF UNDER 24 HRS. Days <b>11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutionalized</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Carl Hubert Fleet</b>				14. MOTHER'S MAIDEN NAME <b>Gladys Rebecca Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		INFORMANT Children's Center, Laurel, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrocephalus</b> DUE TO 344 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>---</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Hour o. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ---					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12/1/60</b> , 19, to <b>12/29/60</b> , 19, that I last saw the deceased alive on <b>12/28/60</b> , 19, and that death occurred at <b>5:30A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>James E. Boyland, M.D.</b> Children's Center, Laurel, Md. <b>12/29/60</b>							
ACTUAL SIGNATURE <b>James E. Boyland, M.D.</b>		DATE SIGNED <b>12/29/60</b>					
PHYSICIAN'S NAME (Type) <b>James E. Boyland, M.D.</b>		Children's Center, Laurel, Md. <b>12/29/60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Jan. 3, 1961</b>		22b. DATE THEREOF <b>Jan. 3, 1961</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) <b>FT. MYER, VIRGINIA</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Hoppe, Jr.</b>		ADDRESS <b>414-15 1/2 S.E.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 3 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hoppe, Jr.</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by \_\_\_\_\_, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

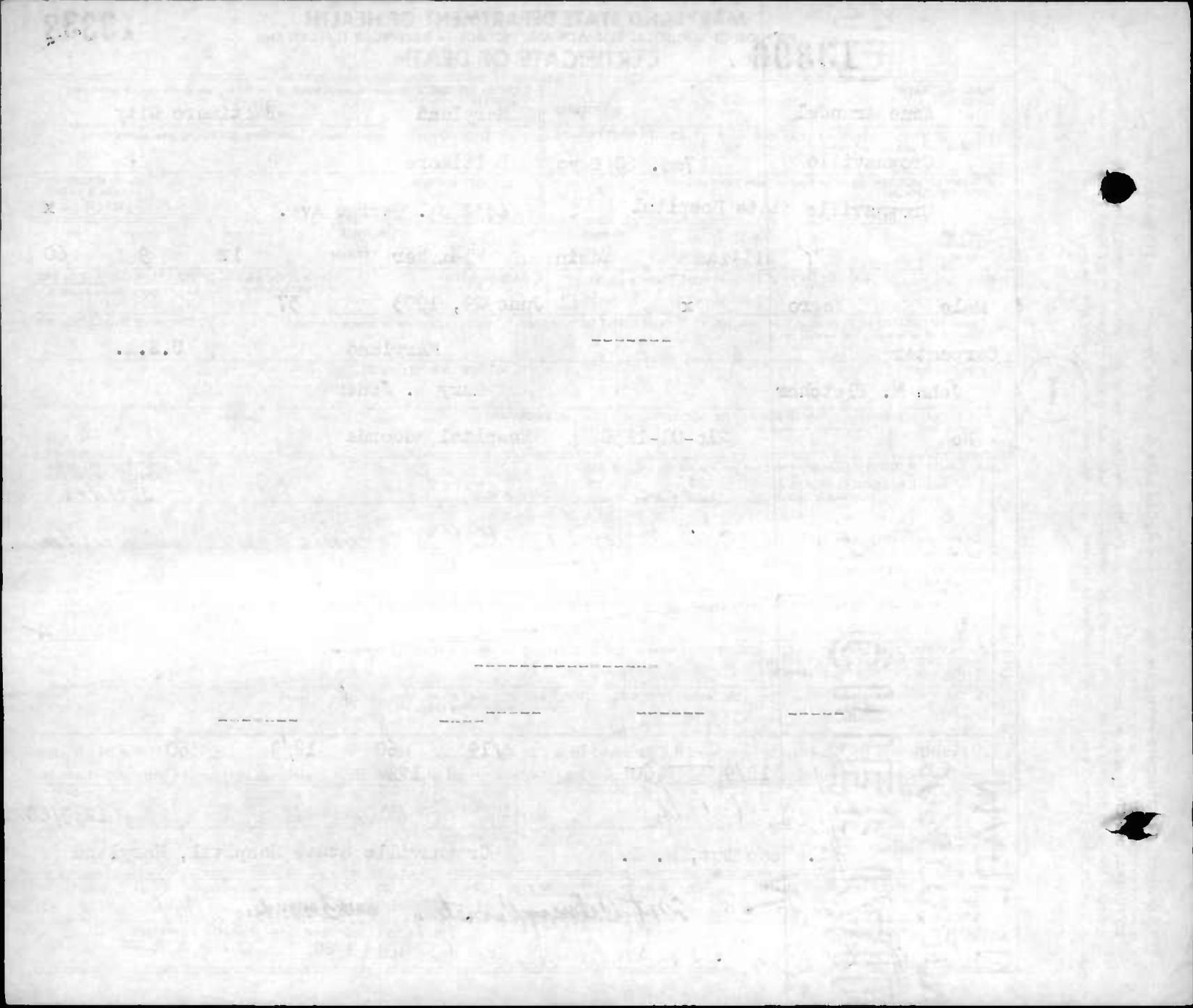
13338

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

**13396**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>7mo. 20 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>4432 St. George Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>William</b>	Middle <b>Edwin</b>	Last <b>Fletcher</b>	4. DATE OF DEATH Month <b>12</b>	Day <b>9</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1903</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John M. Fletcher</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-1150</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO 026 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>C.B.S. Qos. c O.N.S. syphilis</b> DUE TO (c) <b>Gastrectomy</b> since Admission							
INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- 19		20d. INJURY OCCURRED While ----- at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/19</b> , 19 <b>60</b> , to <b>12/9</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12/9</b> , 19 <b>60</b> , and that death occurred at <b>12 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>W. Benedict, M.D.</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>		22e. DATE <b>12/9/60</b>		22f. DATE SIGNED <b>12/9/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-13-60</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>Baltimore, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph L. Russ</i>		ADDRESS <b>2222 W. North Ave</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 13 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13340

13339

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb /		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Crownsville</b>		
3. NAME OF DECEASED (Type or print) <b>Bertha</b>		First <b>E</b>	Middle <b>FORNEY</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept 3, 1879</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Catterton</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mr. Robert L. Forney-Son- Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>274X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO <i>Ac. cerebral insufficiency</i> DUE TO <i>Ch. Arundel manfficiency</i> INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Pernicious anemia. Thyroid insufficiency</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>While at work</b>		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) <b>Maurice Klawans</b> attended the deceased from <b>November 19 59</b> to <b>Dec. 1, 19 60</b> , that (I) <b>last saw the deceased alive on Dec. 1, 19 60</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.				
22a. SIGNATURE <b>Maurice Klawans</b>		11:45 P.M. M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/2/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Maurice Klawans</b>		22d. ADDRESS <b>31 Southgate Ave., Annapolis, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 5, 1960</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Baldwin Memorial Cemetery</b>	23d. LOCATION (City, town, or county) <b>Millersville, Maryland</b> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>	25a. REC'D BY REGISTRAR <b>DEC 7 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Colin S. Krause</b>

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FOR STATE  
HEALTH DEPT.



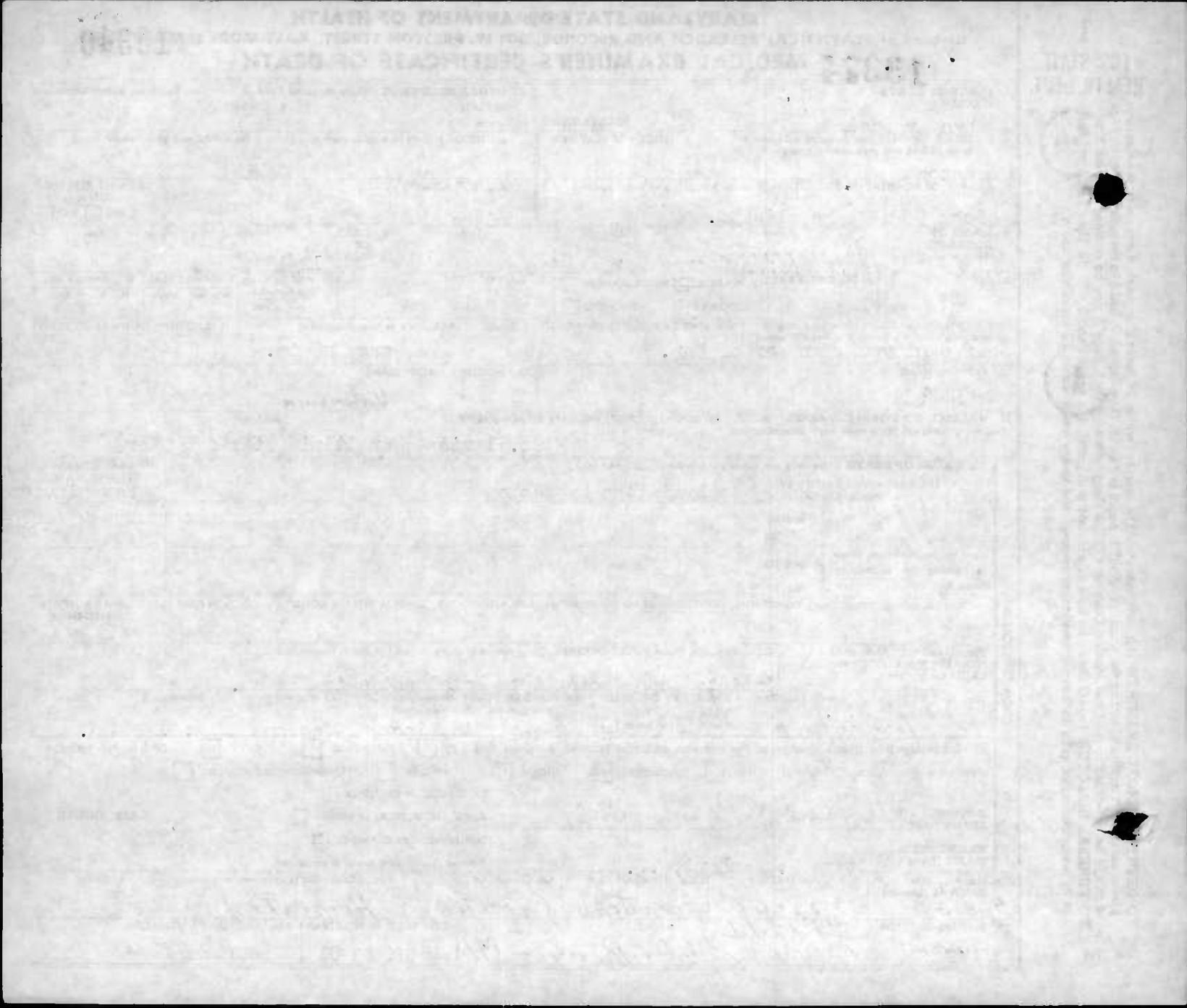
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Items 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13374 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1960

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Anne Arundel		c. LENGTH OF STAY IN lb		e. STATE Same	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		8 years		b. COUNTY Same	
Odenton		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS X Same	
"Boom Town" Annapolis Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH 12/19/60
George Gazda				Month	Day
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/5/14	Year 19
M		W		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Self employed, manager of bar.				Pennsylvania.	
12. CITIZEN OF WHAT COUNTRY?				USA	
13. FATHER'S NAME John Gazda		14. MOTHER'S MAIDEN NAME ? UNKNOWN		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Miss. Gloria Barattini (step daughter)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH Few minutes			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Asphyxiation by smoke			
916.6 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Insisted upon going into hotel while in flames.			
20c. TIME OF INJURY Month, Day, Year Hour e.m. 9 A.M. p.m. 12/19/60 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Hotel (main floor) Odenton A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gustave H. Faubert, M.D.					
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 12/20/60					
22e. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-23-60		22c. NAME OF CEMETERY OR CREMATORY Homestead Cemetery	
22d. LOCATION (City, town, or county) Pa.					
23. FUNERAL DIRECTOR		ADDRESS Hopping & Kirkley, Glen Burnie, Md.		24e. REC'D BY REGISTRAR DATE DEC 23 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13346

## CERTIFICATE OF DEATH

13341

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>		d. STREET ADDRESS <b>Wilhelminor Estates</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USNH, Annapolis, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Karen Elizabeth Grant</b>		First	Middle	Lost	4. DATE OF DEATH <b>GRANT</b>	Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-3-60</b>	9. AGE (in years lost birthday) <b>00 yrs.</b>	IF UNDER 1 YEAR <b>00</b>	IF UNDER 24 HRS. <b>02</b>	Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Carleton Grant</b>		14. MOTHER'S MAIDEN NAME <b>Susan Ann Reichel</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Father - Wilhelminor Estates, Edgewater, Maryland</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATELECTASIS OF LUNGS</b>						INTERVAL BETWEEN ONSET AND DEATH			
752-10 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Naval Academy</b>		20f. (City or town) <b>Annapolis</b>		(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>12/3</b> , 19 <b>60</b> , to <b>12/5</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12/5</b> , 19 <b>60</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Annapolis, Md.</b>		DATE SIGNED	
ACTUAL SIGNATURE <b>N. L. Zouras</b>									
PHYSICIAN'S NAME (Type) <b>N. L. ZOURAS, LT MC USNR</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-6-60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>U.S. Naval Academy</b>		22d. LOCATION (City, town, or county) <b>Annapolis</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b>		ADDRESS <b>San Annapolis Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>John M. Taylor</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be read by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13397

13342

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Pasadena</b>		c. LENGTH OF STAY IN 1b <b>35 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>GEORGE</b>	Middle <b>MILTON.</b>	Last <b>GRAY</b>
4. DATE OF DEATH	Month <b>December</b>	Day <b>5th,</b>	Year <b>1960</b>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White		June 26, 1886
9. AGE (In years less birthday) 74 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter &amp; Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen'l House Reprs. Anne Arundel C6 Md</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Wm C. Gray</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth F Harrison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-01-7177</b>	
17. INFORMANT		Address <b>Mrs May L Gray (Wife-Widow)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>(This hospital)</b> attended the deceased from <b>June 10, 1954</b> to <b>Dec. 5, 1960</b> , that (I) <b>(I)</b> lost sight of the deceased alive on <b>Dec. 1, 1960</b> and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>R. M. McLaughlin</b>	
22b. PHYSICIAN'S NAME (Type) <b>R. M. McLaughlin</b>		22c. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF Thur DEC 8, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Hill Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Brooklyn AA Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Evans</b>		25a. REC'D BY REGISTRAR DATE DEC 6 '60	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

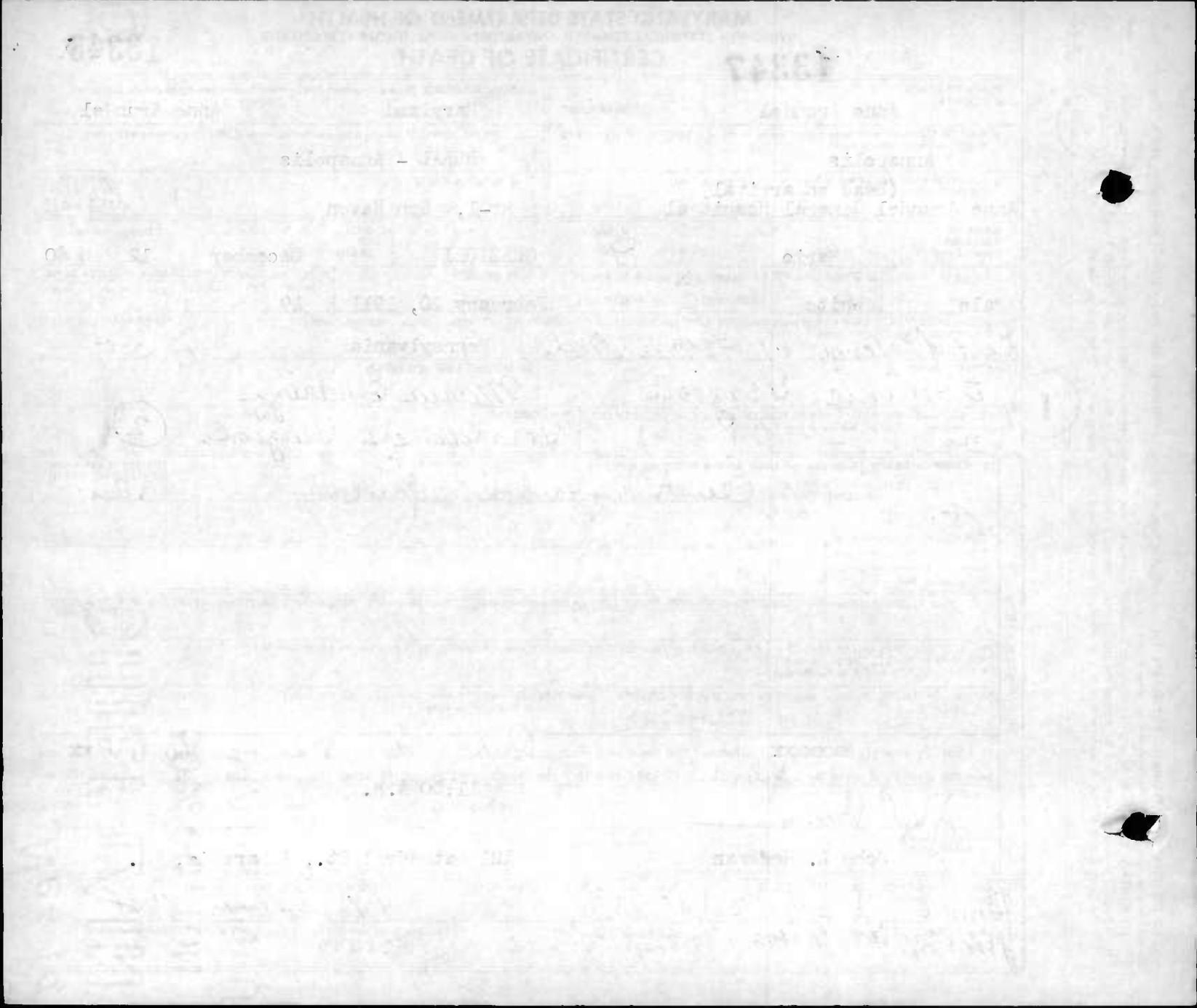
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13343

13347

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Dead on arrival</b>				d. STREET ADDRESS <b>Rt-1, Bon Haven</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Anne Arundel General Hospital										
3. NAME OF DECEASED (Type or print)		First <b>Mario</b>	Middle <b>P</b>	Last <b>GRAZIOLI</b>	4. DATE OF DEATH <b>December 12 1960</b>	Month <b>December</b>	Day <b>12</b>	Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 20, 1911</b>	9. AGE (In years lost birthday) <b>49 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dept of Defense at Ft Meade Md</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>77</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				
13. FATHER'S NAME <b>Dominic Grazioli</b>				14. MOTHER'S MAIDEN NAME <b>Maria Endrizzi</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Geraldine L. Grazioli</b>		Address <b>(2)</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from _____ to _____, 19____, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>July 1 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.		11:00 A.M.								22b. DATE SIGNED
22a. SIGNATURE <b>John L. Hedeman</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) <b>John L. Hedeman</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 16 1960</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St Marys</b>		23d. LOCATION (City, town, or county) <b>Annapolis Md</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sons Annapolis Md</b>		ADDRESS				25a. REC'D BY REGISTRAR DATE <b>DEC 15 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13348 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film G2/6 12-16-60 et

Reg. Dist. No.

13344

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE			
a a. MARYLAND		Md. b. COUNTY a a.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb d. STREET ADDRESS 18 D. # 2 Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) a. a. General Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Terry	Middle Saxon	Last Green III		
4. DATE OF DEATH	Month 12-	Day 6	Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 3-1930		
9. AGE (In years last birthday) 30 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marketing Ordance Dept Westinghouse	10b. KIND OF BUSINESS OR INDUSTRY Marketing Ordance Dept Westinghouse	11. BIRTHPLACE (State or foreign country) St Paul Minn.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Terry S. Green II				
14. MOTHER'S MAIDEN NAME Jacqueline Webster		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			
16. SOCIAL SECURITY NO. 1930-38		17. INFORMANT Pauline B. Green			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) auto accident			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour 12/10 p.m.	Month, Day, Year 12/6 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 50	(County) Anne Arundel	(State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 126.60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-9-1960	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National	22d. LOCATION (City, town, or county) Arlington	(State) VA	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons	ADDRESS Annapolis Md.	24a. REC'D BY REGISTRAR DATE DEC 8 '60	24b. REGISTRAR'S SIGNATURE John S. Kraus		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

MISSOURI STATE BOARD OF EXAMINERS OF DEAF AND DUMB CHILDREN

MISSOURI STATE BOARD OF EXAMINERS OF DEAF AND DUMB CHILDREN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

13345

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>A.A.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLYN</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <b>50</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>III SIXTH AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>MATILDA</b>	Middle <b>GREGOR</b>	Last
4. DATE OF DEATH <b>I2/6/60</b>	Month I2	Day 6	Year 1960
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/30/84</b>
9. AGE (In years lost at birthday) <b>76</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>GOTTLIEB NIERNBERG</b>	14. MOTHER'S MAIDEN NAME <b>AUGUSTINA</b>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO.	INFORMANT <b>FAMILY - SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>Arterio sclerotic Cardio-renal Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> E (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <b>7/25</b> , 19 <b>60</b> , to <b>12/6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12/5</b> , 19 <b>60</b> , and that death occurred <b>12/6</b> , 19 <b>60</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harry Deibel</i>	ADDRESS (Street, city or town, state) <b>1226 Hanover St.</b>		DATE SIGNED <b>12/6/60</b>
PHYSICIAN'S NAME (Type) <b>DR. HARRY DEIBEL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>	22b. DATE THEREOF <b>12/10/60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>GLEN HAVEN</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCULLY - 130 EAST FORT AVENUE</b>		ADDRESS	24a. REC'D BY REGISTRAR DATE <b>DEC 9 '60</b>
			24b. REGISTRAR'S SIGNATURE <i>Charles S. Knapp</i>

81. COMMITTEE - HAVING TO TURN OUT A POSITION ON  
THE PROPOSED STANDARDS

MADE TO STANDARDS

RECOMMENDATION

STANDARDS

COMMITTEE

STANDARDS

RECOMMENDATION

AMERICAN

STANDARDS

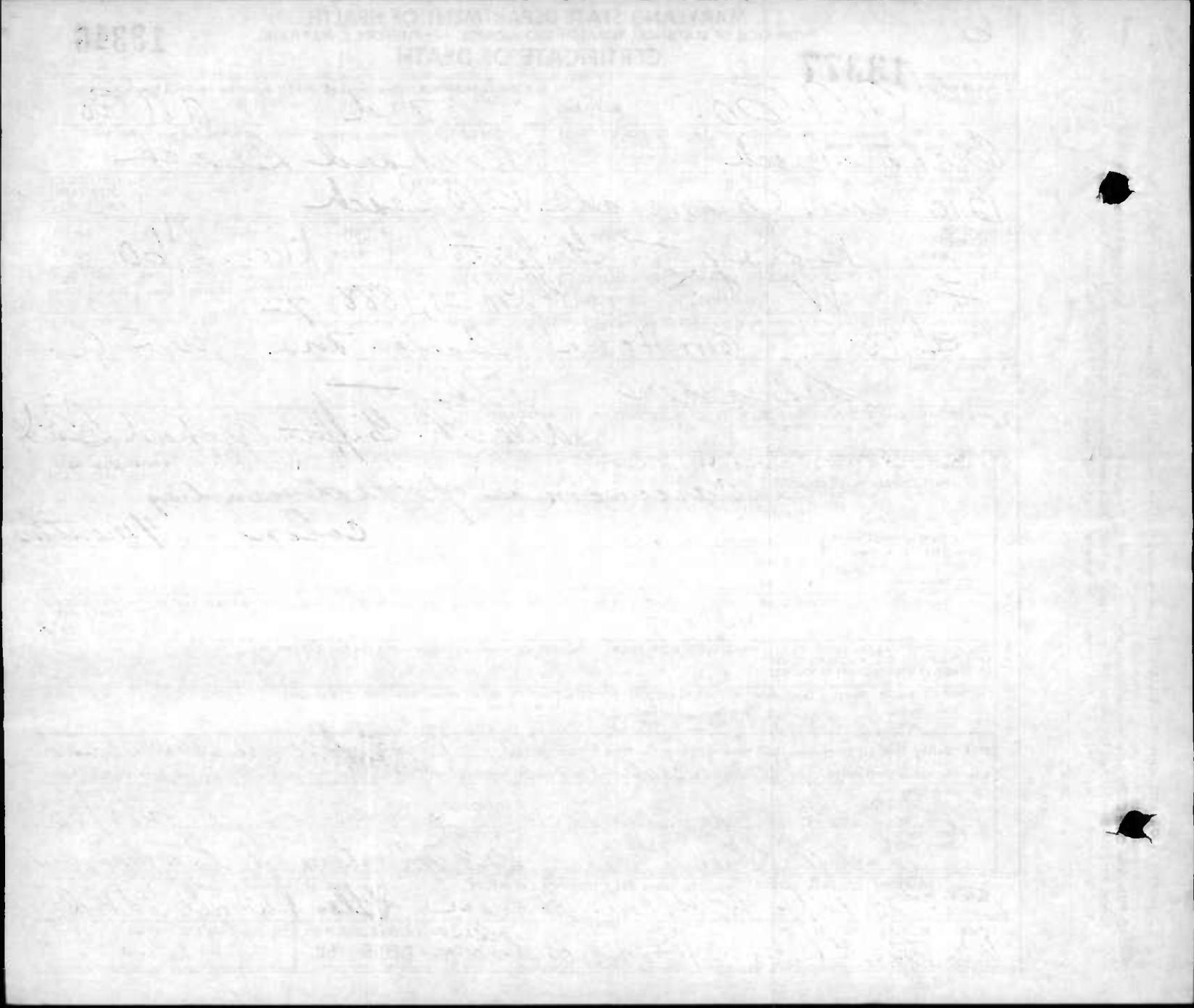
COMMITTEE

STANDARDS

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Rages 4 and 5 will be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										13346		
CERTIFICATE OF DEATH					13377							
1. PLACE OF DEATH o. COUNTY <i>A.A. Co.</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>A.A. Co.</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Orchard Beach</i>					c. LENGTH OF STAY IN lb <i>Orchard Beach</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1210 Beach Promenade</i>					e. STREET ADDRESS <i>1210 Beach</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Daisy T. Griffith</i>					4. DATE OF DEATH <i>Dec. 260</i>					Month	Day	Year
5. SEX <i>F.</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <i>Jan 21, 1888</i>					9. AGE (In years last birthday) <i>72 yrs.</i> IF UNDER 1 YEAR Months <i>72</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Corn Home</i>					11. BIRTHPLACE (State or foreign country) <i>Balto. Md</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>												
13. FATHER'S NAME <i>Schrader</i>					14. MOTHER'S MAIDEN NAME <i>Eliz. —</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>153.2</i> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <i>Allen R. Griffith</i>					Address <i>Orchard Beach</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the descending colon</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>July 1, 1955 to December 21960</i>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Glen Haven</i>		
20f. (City or town) <i>Glen Burnie</i> (County) <i>Md</i> (State)												
21. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1955</i> to <i>December 21960</i> , that (I) (we) lost the deceased alive on <i>December 21960</i> , and that death occurred at <i>9:05 AM</i> ; from the causes and on the date stated above.												
22a. SIGNATURE <i>R.M. McLaughlin</i>					M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <i>12/2/60</i>		
22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>					22d. ADDRESS <i>3708 Mountain Rd. Pasadena, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					23b. DATE THEREOF <i>12/6/60</i>					23c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven</i> 23d. LOCATION (City, town, or county) <i>Glen Burnie, Md.</i> (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wintle F.L. Edmondson</i> ADDRESS <i>An</i>					25a. REC'D BY REGISTRAR <i>Caroline S. Kraus</i> DATE <i>DEC 5 '60</i>					25b. REGISTRAR'S SIGNATURE <i>Caroline S. Kraus</i>		



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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reburied by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13347

13349		CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenland Beach		c. LENGTH OF STAY IN 1b 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenland Beach							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 426 Greenland Beach Road			d. STREET ADDRESS 426 Greenland Beach Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH Dec. 26, Month Year 1960							
5. SEX Female White		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1881		9. AGE (In years last birthday) 79 yrs IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME James McNaney			14. MOTHER'S MAIDEN NAME Julia (Unk)								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Alice Germershausen 1239 Battery Ave.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 153.8 DUE TO <i>Carcinoma Colon</i>						8 months					
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) _____ (c) _____						DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1960</u> to <u>Dec. 26, 1960</u> , that (I) (we) last saw the deceased alive on <u>12/24/1960</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.						22b. DATE SIGNED <u>Dec. 26, 1960</u>					
22a. SIGNATURE <i>J. Brady Smith</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. ADDRESS Ft. Smallwood Rd. Riviera Beach A. A. Co. Md.		
22c. PHYSICIAN'S NAME (Type) <i>Brady Smith</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Dec. 28, 1960</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>New Cathedral Cemetery</i>			23d. LOCATION (City, town, or county) (State) <i>Frederick Road, Baltimore, Md.</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Krause Funeral Home - 1216 S. Charles St.</i>						ADDRESS <i>Doris P. Krause</i>			25a. REC'D BY REGISTRAR <i>DEC 28 '60</i>		
									25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page may be read by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13349

13348

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>1322 Bayridge Ave.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Ethel</b>	Middle <b>May</b>	Last <b>HARLEY</b>
4. DATE OF DEATH	Month <b>December</b>	Day <b>16</b>	Year <b>1960</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>October 24, 1903</b>	9. AGE (In years last birthday) <b>57 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Checker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaners</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Walter Phipps</b>		14. MOTHER'S MAIDEN NAME <b>Maude McCoy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>n</b>		16. SOCIAL SECURITY NO. <b>214-05-0766</b>	17. INFORMANT <b>James Dudley Phipps, Brother- Adm'l, Hgts, Annapo-</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>570-3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO cause (a), stating the under- lying cause lost. (c)		Address <b>6 Porter Drive</b>	
		INTERVAL BETWEEN ONSET AND DEATH <b>Valvular, distal Glenn 3 days.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary artery disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) <b>Attended</b> attended the deceased from <b>Dec. 14, 1960</b> to <b>Dec. 16, 1960</b> , that (I) <b>saw</b> last saw the deceased alive on <b>Dec. 16, 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Maurice Klawans</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/16/60</b>
22c. PHYSICIAN'S NAME (Type) <b>Maurice Klawans</b>		22d. ADDRESS <b>31 Southgate Ave., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 20, 1960</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>All Hallows</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		23d. LOCATION (City, town, or county) <b>Birdsville, Maryland</b>	
		ADDRESS <b>Annapolis, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>DEC 27 '60</b>
			25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>

0-0-412

or

1  
FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. AT 5ME  
5M 7/69

Now

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13400

13349

1. PLACE OF DEATH  
e. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Linthicum

c. LENGTH OF STAY IN lb

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

300 South Camp Meade Road.

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month December  
Day 6th.

Year 19 60

5. SEX

6. COLOR OR RACE

F

W

7. MARRIED  NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

10/13/60

9. AGE (In years  
last birthday)  
yrs.

IF UNDER 1 YEAR

Months 1  
Days 23

IF UNDER 24 HRS.

Hours  
Min.

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Fort Meade Hospital, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James W. Hartung

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Joan Sullivan

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

754.5

Congenital heart diseases

INTERVAL BETWEEN  
ONSET AND DEATH

Sudden

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20e. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour e.m.  
p.m. 19

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

12/6/60

ACTUAL  
SIGNATURE

Gustave H. Faubert, M.D.

EXAMINER'S  
NAME (Type)

Gustave H. Faubert, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF  
8th Dec. 1960

22c. NAME OF CEMETERY OR CREMATORIUM

Lakeview Cemetery

22d. LOCATION (City, town, or country)

(State)

Jamestown, New York

23. FUNERAL DIRECTOR

R. J. Brighton

ADDRESS

Glen Burnie, Maryland

24a. REC'D BY REGISTRAR  
DEC 7 1960

24b. REGISTRAR'S SIGNATURE  
G. S. Faubert

2050262XV3

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by me, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

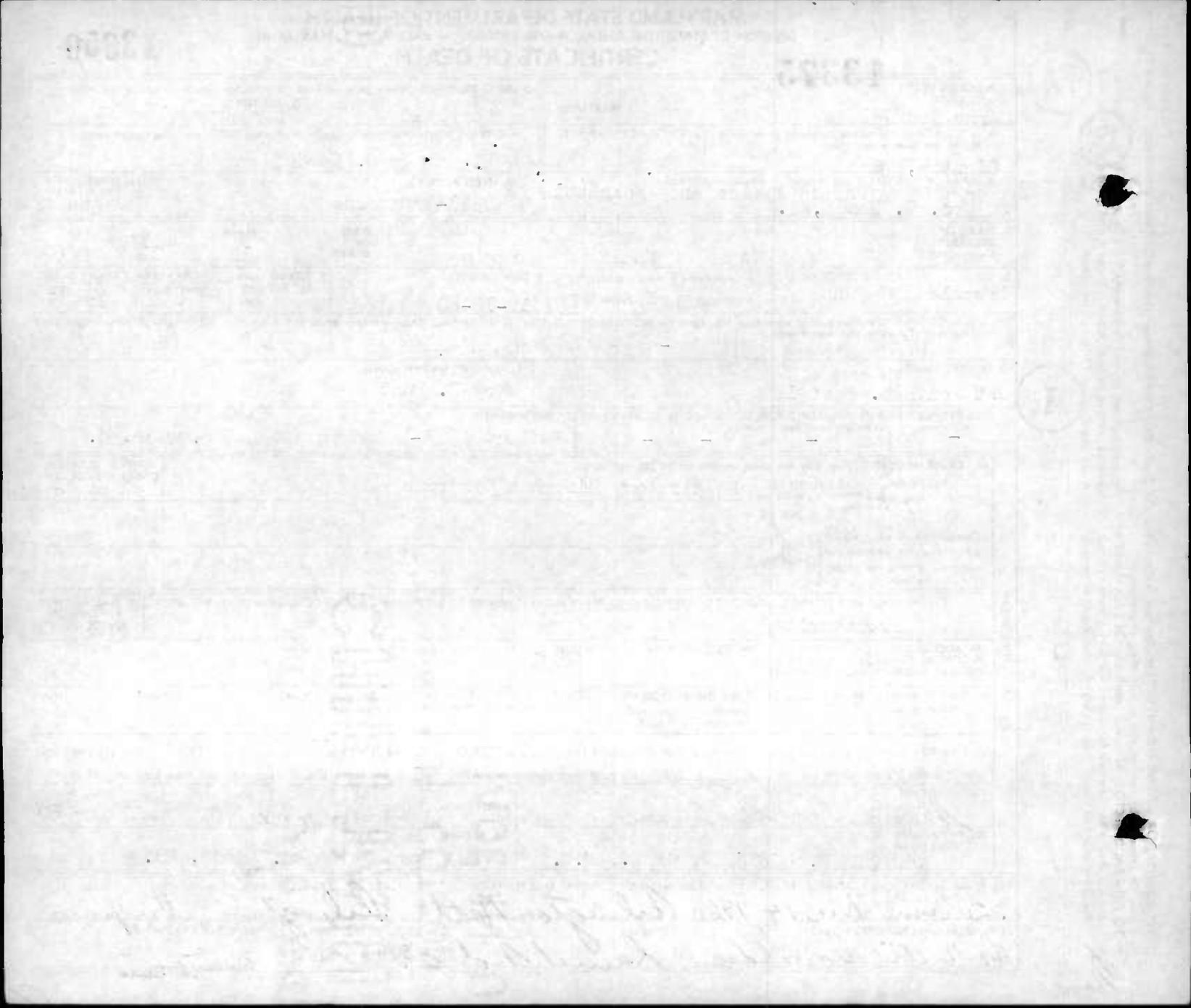
**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

**13350**

**CERTIFICATE OF DEATH**

**13375**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Odenton, Md</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft. George G. Meade</b>		d. STREET ADDRESS <b>7311-E Gammons</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>United States Army Hospital Ft Geo. G. Meade, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>EVA</b>	Middle <b>MARIE</b>	Last <b>Hartwig</b>	4. DATE OF DEATH	Month <b>12</b>	Day <b>11</b>	Year <b>19 60</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> N / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-10-60</b>	9. AGE (In years last birthday) yrs. <b>26</b>	IF UNDER 1 YEAR Months <b>26</b>	IF UNDER 24 HRS. Days <b>5</b>	Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>SFC Keith E. Hartwig</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Hunt</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>- - -</b>		17. INFORMANT <b>Father</b>		Address <b>7311-E Gammons Ft Geo G. Meade, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>774X</b>		Respiratory Distress Syndrome				INTERVAL BETWEEN ONSET AND DEATH <b>26 Hrs 5 Min</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Prematurity</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>10 Dec 1960</b> to <b>11 Dec 1960</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.								
22a. SIGNATURE <b>Sherman S. Robinson</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>11 Dec 60</b>		
22c. PHYSICIAN'S NAME (Type) <b>SHERMAN S. ROBINSON, Capt., M.C.</b>		22d. ADDRESS <b>USA Hosp Ft Geo G. Meade, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Dec 14, 1960</b>		23b. DATE THEREOF <b>Arlington Natl</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington</b>		23d. LOCATION (City, town, or county) (State) <b>Virginia</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>DeWitt Randolph, Laurel, Md</b>		ADDRESS <b>2050286xv3</b>		25a. REC'D BY REGISTRAR <b>DEC 15 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

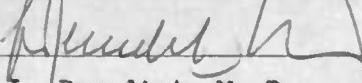
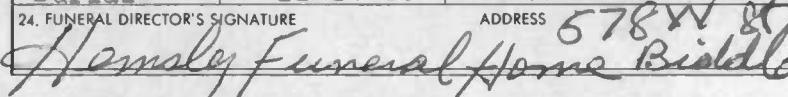
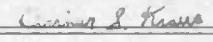
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13351

13401

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>8 yrs. 3 mo. 17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3 VD 1-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>703 N. Mount Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Hawkins</b>	Middle	Last <b>Addie</b>	4. DATE OF DEATH	Month <b>12</b>	Day <b>21</b>	Year <b>19 60</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1883?</b>		9. AGE (in years last birthday) <b>77? yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Dollie Jones Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>							
DUE TO <b>420.1</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis</b>							
DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) -----							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- p. m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (This hospital) attended the deceased from <b>9/4 19 52</b> to <b>12/21 19 60</b> that (I) (we) lost saw the deceased alive on <b>12/21 19 60</b> and that death occurred at <b>10:15</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED <b>12/22/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-24-60</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Auburn Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS <b>578 W. 81st</b>					
		25a. REC'D BY REGISTRAR DATE <b>DEC 27 '60</b>					
		25b. REGISTRAR'S SIGNATURE 					

SEARCHED INDEXED SERIALIZED FILED  
FEB 10 1948

W. W. STANLEY

LAWRENCE COUNTY

PROBATE DIVISION

CHARTER NUMBER 4-107

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

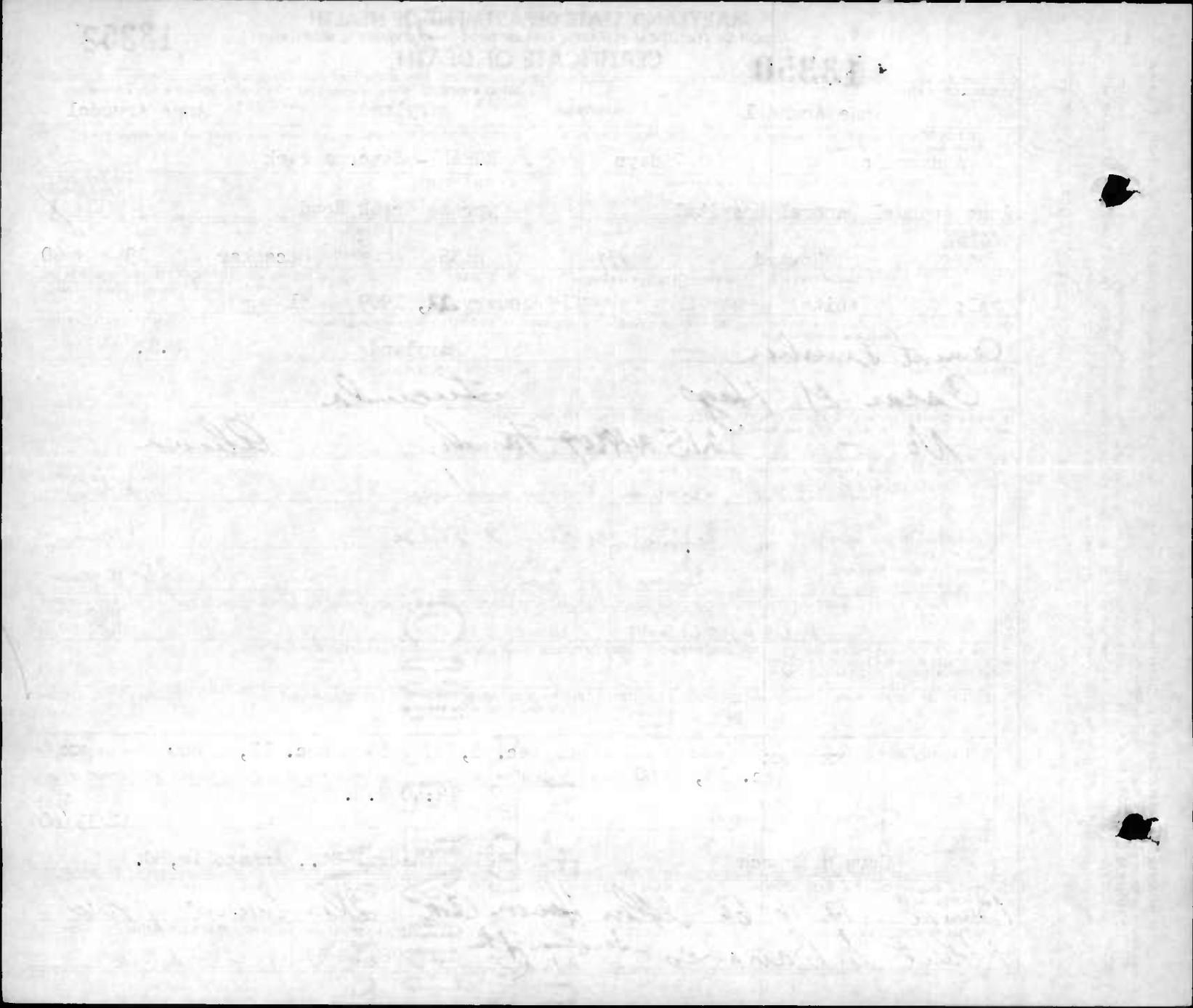
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13352

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 7 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>X</del> RURAL - Severna Park				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS Cypress Creek Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Howard	Middle <i>m</i>	Last HAYS	4. DATE OF DEATH December	Month 13	Day 19	Year 60
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1909	9. AGE (In years lost birthday) 51 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Cement Finisher</i>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME <i>Oscar G. Hays</i>		14. MOTHER'S MAIDEN NAME <i>Lucinda</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>215 349609</i>		17. INFORMANT <i>Family</i>		Address <i>Alma</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5811</i>		DUE TO <i>Terminal broncho pneumonia</i>				<i>2 days</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <i>Ruptured esophageal varices</i>				<i>1 week</i>		
		(c) DUE TO <i>Cirrhosis of liver</i>				<i>5-10 years</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>ALCOHOLISM</i>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Dec. 6, 1960								
21. I certify that (I) <i>(Physician)</i> attended the deceased from Dec. 6, 1960, to Dec. 13, 1960, that (I) <i>(Physician)</i> last saw the deceased alive on Dec. 13, 1960, and that death occurred at M, from the causes and on the date stated above.								
22a. SIGNATURE <i>Gerald Church</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/13/60				
22c. PHYSICIAN'S NAME (Type) Gerald Church		22d. ADDRESS 121 Cathedral St., Annapolis, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-16-60		23c. NAME OF CEMETERY OR CREMATORIAL <i>Elm Haven Cem.</i>		23d. LOCATION (City, town, or county) <i>Bethesda</i> (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert J. Bananca</i>		ADDRESS <i>Severna Park</i>		25a. REC'D BY REGISTRAR DATE DEC 19 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13378

## CERTIFICATE OF DEATH

13353

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>A.A.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riviera Beach</b>		c. LENGTH OF STAY IN 1b c. STREET ADDRESS <b>Riviera Beach</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>209 Hilltop Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD W. HEALY</b>		First <b>EDWARD</b>	Middle <b>W.</b>
4. DATE OF DEATH <b>19/20/60</b>	Month <b>Month</b>	Day <b>Day</b>	Year <b>Year</b>
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/25/96</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Upholsterer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.C.G. Ret.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edward M.</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWI</b>	
INFORMANT <b>Family - Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>183 X</b> DUE TO <b>Carcinoma Lung</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b> (County) <b>Baltimore</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>April 1960</b> , to <b>Dec. 1960</b> , that I last saw the deceased alive on <b>Dec. 19, 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8471 21st Street, Baltimore, Md.</b> DATE SIGNED <b>12/23/60</b>			
ACTUAL SIGNATURE <b>J. Brady Smith</b>		PHYSICIAN'S NAME (Type) <b>J. Brady Smith</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		22b. DATE THEREOF <b>12/23/60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully - 130 E. Fort Avenue</b>		ADDRESS	
		24a. REC'D BY REGISTRAR DATE <b>DEC 23 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

86861

STANDARD - FLASH TO STANDARD

FLASH TO STANDARD

86861

DATE

TIME

DATA SHEET

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13402

## CERTIFICATE OF DEATH

Reg. Dist. No.

13354

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE					
Anne Arundel MARYLAND		b. COUNTY Maryland Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, and give nearest town)  Cleen Burnie	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 60 Glen Burnie					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1007 Balto.-Annap.-Blvd., N.E.	d. STREET ADDRESS 1007 Balto.-Annap.-Blvd., N.E.	d. STREET ADDRESS 1007 Balto.-Annap.-Blvd., N.E.					
3. NAME OF DECEASED (Type or print)	First JOHN	Middle HADE	Last HENKEL				
4. DATE OF DEATH	Month Dec	Day 1	Year 1960				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-1888	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (ret.)		10b. KIND OF BUSINESS OR INDUSTRY B.+O. R.R.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel G. Henkel		14. MOTHER'S MAIDEN NAME Sarah Wade		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-05-5133		17. INFORMANT Mrs. Anna L. Henkel		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } DUE TO (b) Coronary Thrombosing Coronary artery disease (c) DUE TO (c) ARTERIOSCLEROTIC Heart Disease and Hypertension	INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ACTUAL SIGNATURE JOSEPH TALER, M.D.		ADDRESS (Street, city or town, state) 102 Br A Blvd. N.E. Cleen Burnie, Md.		DATE SIGNED 12-1-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-4 Dec. 1960		22c. NAME OF CEMETERY OR CREMATORIUM Western Cem.		22d. LOCATION (City, town, or county) Balto. 14d (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R.V. G. Ingerson		ADDRESS Glen Burnie's 14d		24a. REC'D BY REGISTRAR DATE DEC 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

01 JOURNAL OF THE AMERICAN RAILROAD HISTORICAL ASSOCIATION

**TO HOSPITAL & ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13355

13351

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>(Dead on arrival)</b> <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>207 Lockwood St.,</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Madeline</b>	Middle <b>GROLZ</b>	Last <b>HEROLD</b>	
4. DATE OF DEATH	Month <b>December</b>	Day <b>4</b>	Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 9, 1896</b>	
9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months <b>—</b>	IF UNDER 24 HRS. Days <b>—</b>	Hours <b>—</b>	Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. FATHER'S NAME <b>CHARLES GROLZ</b>		14. MOTHER'S MAIDEN NAME <b>Emily Christy</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Anthony Herold</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO metastasis		<b>3 hrs.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>carcinoma of breast rt. (resected)</b>		<b>18 mos.</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>diabetes mellitus</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) <b>(Signature)</b> attended the deceased from <b>Apr. 59</b> to <b>Dec. 4, 1960</b> , that (I) <b>(Signature)</b> last saw the deceased alive on <b>Dec. 3, 1960</b> , and that death occurred at <b>8:40 AM</b> the causes and on the date stated above.		22b. DATE SIGNED <b>12/6/60</b>		
22a. SIGNATURE <b>Samuel Borssuck</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <b>Amos Garrett</b>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/6/60</b>
22c. PHYSICIAN'S NAME (Type) <b>Samuel Borssuck</b>		22d. ADDRESS <b>Amos Garrett Blvd., Annapolis, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>12-6-60</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor &amp; Sons Annapolis, Md.</b>		ADDRESS		25d. LOCATION (City, town, or county) <b>Prince George Co. MD.</b>
				25e. REC'D BY REGISTRAR DATE DEC 8 '60
				25b. REGISTRAR'S SIGNATURE <b>Carroll S. Kraus</b>

... con el que se ha de hacer con  
cinetato:

(sección) ... con el que se ha de hacer

en este caso el

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13403												Reg. Dist. No. 13356	
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY A.A. Co.											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shoreline		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesington Md									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First James	Middle E.	Last Holland	4. DATE OF DEATH Month 12 Day 31 Year 1960								
S. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1930		9. AGE (In years last birthday) 30 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pile Driving		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chesington, Md		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Edward Holland Sr		14. MOTHER'S MAIDEN NAME Hilda Brown											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Korean		16. SOCIAL SECURITY NO. 216-34-8302		17. INFORMANT James E. Holland Sr		Address Chesington, Md							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 850 X DUE TO Drowning Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause lost.												INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell overboard from own oyster boat											
20c. TIME OF INJURY Month, Day, Year Hour a.m. x P.M. 12.31 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay		20f. (City or town) (County) (State) A.A. Md.							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE E. L. Wharff		DATE SIGNED 1/3/60											
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 4, 1961		22c. NAME OF CEMETERY OR CREMATORIUM Brown Cemetery		22d. LOCATION (City, town, or county) Chesington		(State) Md					
23. FUNERAL DIRECTOR'S SIGNATURE T & Hauling & Son Galesville, Md		ADDRESS		24a. REC'D BY REGISTRAR Date Jan 9 '61		24b. REGISTRAR'S SIGNATURE Charles S. Kraus							



*1 plain copy at*

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13404 13357

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 31 years		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Springs		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown		15X-2	
3. NAME OF DECEASED (Type or print)		First Howard	Middle 0	Last Hopkins	4. DATE OF DEATH Month 12 Day 19 Year 1960.		
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886		9. AGE (In years from birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Lewis Hopkins				14. MOTHER'S MAIDEN NAME Emma Berry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure INTERVAL BETWEEN ONSET AND DEATH							
443 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Chronic Brain Syndrome ass. with Hypertensive -					
		DUE TO (c) Cardiovascular Disease.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month Day Year Hour o. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/19/1960 to 12/19/1960, that (I) (we) last saw the deceased alive on 12/19/1960, and that death occurred at 12/19/1960, from the causes and on the date stated above.							
22a. SIGNATURE <i>L. Benedict, M. D.</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/19/60		
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-29-60		23b. DATE THEREOF 12-29-60		23c. NAME OF CEMETERY OR CREMATORIAL 2107 md.		23d. LOCATION (City, town, or county) Baltimore, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, S-Ams J. H.				ADDRESS		25a. REC'D. BY REGISTRAR DEC 30 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Trahan

100000000

Amphetamine

Inactive name

equivalent weight

Weight X

affine name

monomer

list with other affine name

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substance

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other

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be recd. by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13358

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1089 MAIN ST.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>ANNAPOULIS</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>SARAH</b>	Middle <b>JANE</b>	4. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>1960</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 15, 1875</b>
9. AGE (In years lost birthday) <b>85</b> yrs.	10. IF UNDER 1 YEAR Months <b>85</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>SAMUAL MONTGOMERY</b>	14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>	16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>MRS THOMAS H. GROSE #2</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Obstructive jaundice</b>			
155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of cystic duct</b>			
155.1 DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Arterosclerotic cardiovascular disease with congestive failure</b>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m.      Day      Year p. m.      19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) <b>Richard N. Peeler</b> attended the deceased from <b>Dec. 14, 1960</b> , to <b>Dec. 22, 1960</b> , that (I) <b>last saw the deceased alive on Dec. 22, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22. SIGNATURE <b>Richard N. Peeler</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/22/60</b>
22c. PHYSICIAN'S NAME (Type) <b>Richard N. Peeler</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-24-1960</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>HILLCREST MEM.</b>	23d. LOCATION (City, town, or county) <b>ANNAPOLIS MD.</b> (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR - SOUS</b>		ADDRESS <b>ANNAPOLIS MD.</b>	25a. REC'D BY REGISTRAR DATE <b>DEC 27 '60</b>
			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

2008

10/26/07

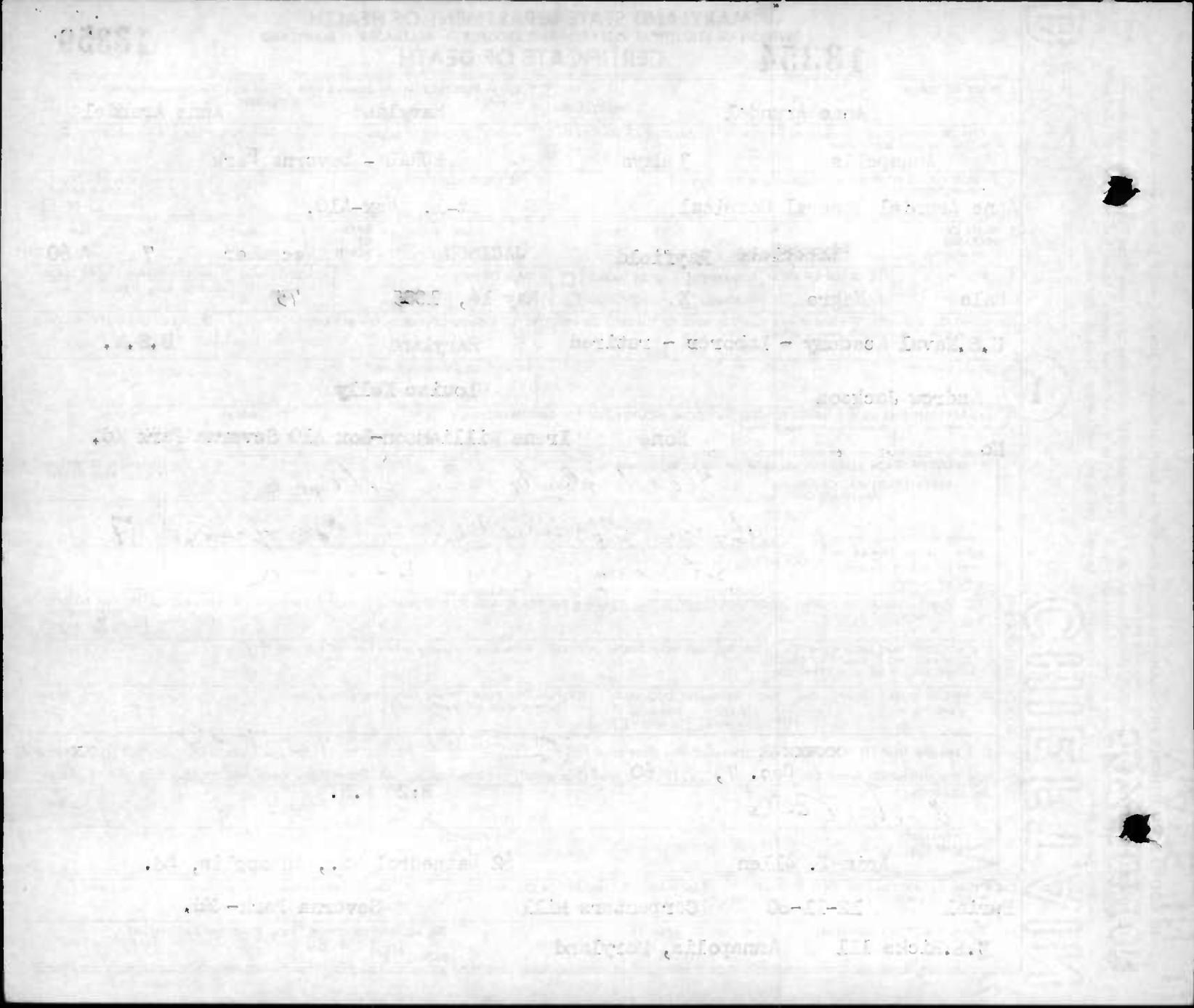
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SECRET

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												13354		13359					
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>						b. COUNTY <b>Maryland</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>						c. LENGTH OF STAY IN 1b <b>3 days</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Severna Park</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>						d. STREET ADDRESS <b>Rt-1, Box-410,</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First <b>Matthew</b>	Middle <b>Rayfield</b>	Last <b>JACKSON</b>	4. DATE OF DEATH <b>December</b>			Month <b>7</b>	Day <b>19</b>	Year <b>1960</b>								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 16, 1885</b>			9. AGE (In years lost/birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>		11. IF UNDER 24 HRS. Days <b>0</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Naval Academy - Labored - retired</b>						11. BIRTHPLACE (State or foreign country) <b>Maryland</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Andrew Jackson</b>						14. MOTHER'S MAIDEN NAME <b>Louise Kelly</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address <b>Irene Williamson-Box 410 Severna Park Md.</b>										
No			None			Irene Williamson-Box 410 Severna Park Md.													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>561.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO <b>Electrolyte Imbalance</b> <b>Bowel Obstruction + Gurgling 7</b> <b>Strangulated Hernia</b>												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)																
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <b>Severna Park</b>		(County) <b>Md.</b>		(State) <b>Md.</b>						
21. I certify that (I) <b>Arthur S. Hicks</b> attended the deceased from <b>5-5-60</b> to <b>12-7-60</b> , that (I) <b>last saw the deceased alive on Dec. 7, 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.												22b. DATE SIGNED <b>8:20 A.M.</b>							
22a. SIGNATURE <b>O. S. Hicks</b>												M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) <b>Aris T. Allen</b>												22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>							
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12-11-60</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Carpenters Hill</b>			23d. LOCATION (City, town, or county) <b>Severna Park- Md.</b>		(State)								
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.E.Hicks III</b>												ADDRESS <b>Annapolis, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hicks</b>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied upon by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. 13360

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>10</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USNH, Annapolis, Md.</b>		d. STREET ADDRESS <b>11 Maryland Avenue</b>		4. DATE OF DEATH <b>December 15th 1960</b>		Month Day Year									
3. NAME OF DECEASED (Type or print)	First <b>Horace</b>	Middle <b>Homer</b>	Last <b>Jalbert</b>	5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/1891</b>	9. AGE (In years last birthday) <b>69 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USN - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Recruit Admiral S.S.</b>		11. BIRTHPLACE (State or foreign country) <b>Rhode Island</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>Joseph J. Jalbert</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Pinault</b>		Address											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WV1 and 11</b>		17. INFORMANT <b>Wife - 11 Maryland Avenue, Annapolis, Md</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO 450 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gangrene left thigh with infection</b> DUE TO 3 weeks (c) <b>Generalized Arteriosclerosis Obliterans</b> 10 years															
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>11/7</b> , 19 <b>60</b> , to <b>12/15</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12/15</b> , 19 <b>60</b> , and that death occurred at <b>11:15 AM</b> , from the causes and on the date stated above.															
ADDRESS (Street, city or town, state) <b>USNH, ANNAPOLIS, MARYLAND</b> DATE SIGNED															
ACTUAL SIGNATURE <b>R. G. Williams, Jr.</b>		M.D. <b>USNH, ANNAPOLIS, MARYLAND</b>													
PHYSICIAN'S NAME (Type) <b>R. G. WILLIAMS, JR., CDR MC USN</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec-19-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Naval Academy Cemetery</b>		22d. LOCATION (City, town, or county) <b>Annapolis</b>		(State) <b>Md</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Taylor Sr.</b>		ADDRESS <b>Annapolis, Md.</b>		24a. REC'D. BY REGISTRAR <b>DECEMBER 19 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>									



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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13356

13361

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE				
<i>A. A.</i> <i>Annapolis</i>		<i>Maryland</i> <i>Annapolis</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				
<i>74 Pleasant Street</i>		<i>74 Pleasant St.</i>				
3. NAME OF DECEASED (Type or print)		First	Middle			
<i>Elizabeth</i>			<i>Johnson</i>			
4. DATE OF DEATH		Month	Day			
		<i>12</i>	<i>31</i>			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months Days Hours Min.	10. IF UNDER 24 HRS. Months Days Hours Min.
<i>Female</i>		<i>Col</i>	<i>5-25-1909</i>	<i>51</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>Housewife</i>				<i>Maryland</i>		<i>U.S.A.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address		
<i>Charles Green</i>		<i>Naomi Johnson</i>		<i>Naomi Kirby 74 Pleasant St.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)
<i>No</i>						<i>443x</i> <i>Arterio Sclerotic Hypertension</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)				
						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>811</i>		20f. (City or town) (County) (State)
						<i>13361</i>
21. I certify that (I) (this hospital) attended the deceased from <i>1/31/61</i> to <i>1/31/61</i> , that (I) (we) last saw the deceased alive on <i>1/31/61</i> , and that death occurred at <i>109</i> M, from the causes and on the date stated above.						
22a. SIGNATURE <i>R.H. Richardson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1/4/61</i>		
22c. PHYSICIAN'S NAME (Type) <i>R.H. Richardson M.D.</i>		22d. ADDRESS <i>110 - clay street Annapolis Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-5-1961</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Brewer Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese # Anna Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 9 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Price</i>

**TO HOSPITAL**  
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**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours by the hospital or attending physician.

**TO:** After this certificate has been signed by the attending physician and completely filled in by

be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13357

Item 11 FilmG276 12-16-60 et

## CERTIFICATE OF DEATH

13362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b <b>10</b>					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			d. STREET ADDRESS <b>138 Lafayette Ave.</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>138 Lafayette Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>HARRY</b>	Middle <b>A</b>	Last <b>KLAWANS</b>	4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1890</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Prop.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Dress Shop</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				
13. FATHER'S NAME <b>David Klawansky</b>			14. MOTHER'S MAIDEN NAME <b>Lena (Unknown)</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>218 32 2074</b>	17. INFORMANT <b>Mrs Fannie Klawans- Wife- Same as # 2</b>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420-1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Diabetes M.</b> (b) <b>Genuvalgic arterie atherosclerosis</b> DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <b>W. off.</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes M.</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-1-60</b> , to <b>12-1-60</b> , 1960, that I last saw the deceased alive on <b>12-1-60</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	DATE SIGNED <b>12-2-60</b>	
ACTUAL SIGNATURE <b>Frank Shipley</b> M.D.								
PHYSICIAN'S NAME (Type) <b>Frank Shipley M.D.</b>						<b>Annapolis, Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 8, 1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Hebrew Friendship Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Shipley</b>		ADDRESS <b>Hopping Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Cyrus S. Powell</b>		
Annapolis, Maryland								



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13405

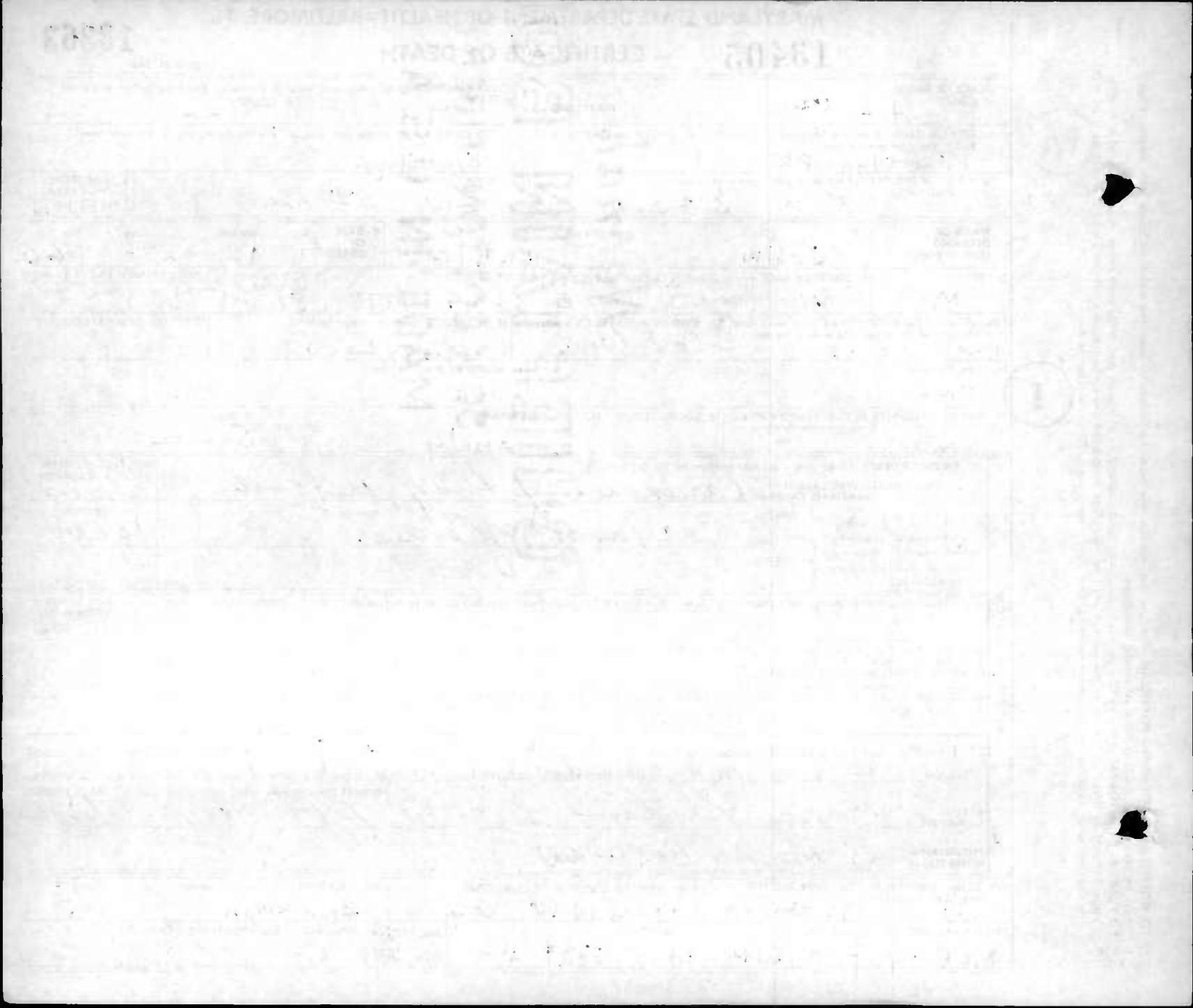
## CERTIFICATE OF DEATH

13363

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn PK</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>50 Brooklyn</i>		d. STREET ADDRESS <i>15 W. 3rd Ave.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5 W. 3rd Ave.</i>				d. STREET ADDRESS <i>15 W. 3rd Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>JOHN</i>	Middle	Last <i>KREIG</i>	4. DATE OF DEATH Month <i>12</i>	Day <i>27</i>	Year <i>1960</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-24-1879</i>	9. AGE (In years last birthday) <i>81</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook. Eng.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>14C-100</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>UNK</i>		14. MOTHER'S MAIDEN NAME <i>UNK</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO.		INFORMANT <i>FAMILY</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung, metastatic</i> DUE TO <i>157</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of Pancreas</i> (c) <i>1 year</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/16/50</i> to <i>12/29/60</i> , that I last saw the deceased alive on <i>12/27/60</i> , and that death occurred at <i>10 a.m.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Benjamin Berdann</i>		ADDRESS (Street, city or town, state) <i>5010 A Atlantic Hwy</i>		DATE SIGNED <i>12/28/60</i>			
PHYSICIAN'S NAME (Type) <i>BENJAMIN BERDANN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>15</i>	22b. DATE THEREOF <i>12-30-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Ocean Hill Cem.</i>		22d. LOCATION (City, town, or county) <i>Brooklyn</i>		(State) <i>MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCullough Funeral Home</i>		ADDRESS <i>130 E. FORT AVE.</i>		24a. REC'D BY REGISTRAR <i>JAN 3 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Calling &amp; Home</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13364

Reg. Dist. No.

13406

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Md.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>				c. LENGTH OF STAY IN 1b <b>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</b> <b>Pasadena</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 9 - Box A. Anne Arundel, Md.</b>				d. STREET ADDRESS <b>Rt. 9</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First <b>JOHN</b>	Middle <b>CHARLES</b>	Last <b>KRISS</b>	4. DATE OF DEATH Dec. <b>5 19 60</b>	Month <b>Dec.</b>	Day <b>5</b>	Year <b>1960</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>May 25 1890</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. US HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Printer</b>			11. BIRTHPLACE (State or foreign country) <b>Md.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>								
13. FATHER'S NAME <b>Charles Kriss</b>				14. MOTHER'S MAIDEN NAME <b>Beatrice ?</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>		Address <b>Above</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <b>Cadence drive</b>  434-4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)  DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <b>Needer</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>E. L. Whorff</i>		DATE SIGNED <b>12-5-60</b>						
EXAMINER'S NAME (Type) <b>E. L. Whorff</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Glen Haven Cem.</b>		22d. LOCATION (City, town, or county) <b>Glen Burnie</b>		
(State) <b>Md.</b>								
23. FUNERAL DIRECTOR'S SIGNATURE <b>SEVERNA PARK FUNERAL HOME</b>		ADDRESS <b>Robert S. Barranco</b>		24a. REC'D BY REGISTRAR <b>REC 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Robert S. Barranco</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

OF BROMIDES - HIGHLIGHTS OF THE RECENT LITERATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13365

Reg. Dist. No.

13358

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>Hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>817 Spa Road</b>				d. STREET ADDRESS <b>927 Spa Road</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Joseph Kyler</b>		First	Middle	Last	4. DATE OF DEATH <b>December 7 1960</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>Oct. 15-1914</b>	9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gen. Utilities - U.S. Naval Exp. Station</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Thomas Kyler</b>				14. MOTHER'S MAIDEN NAME <b>Airy Crompton</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Florence Green- 817 Spa Road-Annapolis, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4 = 4.4</b> DUE TO <b>and die</b>								
Conditions, if any, which gave rise to immediate cause (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Elvin Hard</i>		DATE SIGNED <i>12.7-60</i>						
EXAMINER'S NAME (Type) <i>Elvin Hard</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 10-60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Brewer Hill</b>		22d. LOCATION (City, town, or county) <b>Annapolis, Md.</b>			(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E.Hicks III</b> ADDRESS <b>Annapolis, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 14 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Clinton S. Krause</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

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1) *Chlorophytum comosum* L. (Liliaceae)

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by [redacted] page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

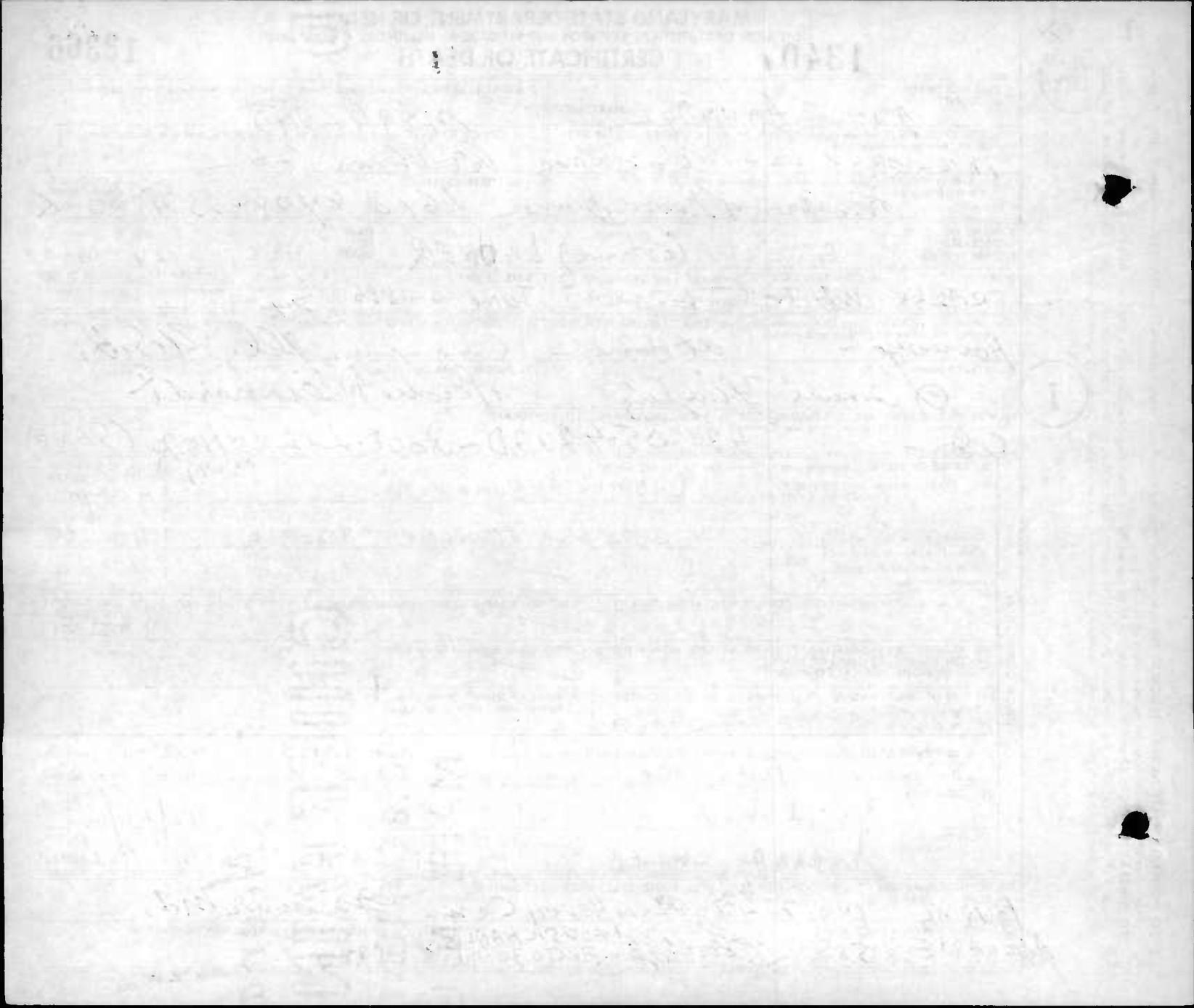
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13407

**CERTIFICATE OF DEATH**

13366

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Anne Arundel Maryland</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL (and give nearest town)	
<i>Millersville</i>		<i>About 10 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Woodlawn Nursing Home</i>		<i>1618 Cypress St Baltimore 26 - 3 Vol-4</i>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
<i>STELLA (Estelle) LADNER</i>		Month	Day Year
5. SEX	First MIDDLE	Last	DEC. 24 1960
<i>Female</i>	<i>Widow</i>	<i>74 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
<i>White</i>		8. DATE OF BIRTH	
		<i>June 10-1886</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Housewife</i>		<i>at home -</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Champaign Ill. U.S.A.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Samuel Yingling</i>		<i>Lodie Reinhardt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> YES, no, or unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>220-05-42220</i>	
17. INFORMANT		Address	
<i>Robt. L. Ladner (Same son)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>4 days.</i>	
<i>331X</i>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		<i>Cerebro Vascular Disease</i>	
20c. TIME OF INJURY Month Day Year Hour a.m. 10 20 p.m. 19		20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> <u>1960</u> , to <u>12/24</u> , <u>1960</u> ; that (I) (we) last saw the deceased alive on <u>12/20</u> <u>1960</u> ; and that death occurred at <u>PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
<i>Gerard Church</i>		<i>12/25/60</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
<i>GERARD CHURCH</i>		<i>121 Caton Dr. Si Annapolis</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<i>BURIAL</i>		<i>Dec. 28-1960</i>	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town, or county) (State)	
<i>Glen Haven Cem.</i>		<i>Glen Burnie Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
<i>ANTONIUS EVANGELIS SON</i>		ADDRESS <i>4005 Charles St</i> DATE <i>DEC 28 60</i>	
		25b. REGISTRAR'S SIGNATURE	
		<i>Antonius Evangelis</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**13359 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **13367**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>531 West Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>DORMAN</b>		First <b>H</b>	Middle <b></b>	Last <b>LEWIS</b>	4. DATE OF DEATH <b>DECEMBER 3, 1960</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 15, 1935</b>	9. AGE (in years last birthday) <b>25 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Equipment Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Road Const.</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Robert Hayes Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Maudy Walston</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212 50 3576</b>		17. INFORMANT <b>Mrs Laverne Cox Lewis- Wife- Same as # 2</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture Spine</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <b>Linhardt</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident Rh 750.</b>						
20c. TIME OF INJURY Hour <b>a.m. 12-3 p.m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) <b>St. Paul</b>	(County) <b>Minneapolis</b>	(State) <b>MD</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Elmer G. Linhardt</b>		DATE SIGNED <b>1/13/60</b>						
EXAMINER'S NAME (Type) <b>Elmer G. Linhardt</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>		22b. DATE THEREOF <b>Dec. 5, 1960</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Southport Cemetery</b>		22d. LOCATION (City, town, or county) <b>Southport, N.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>		ADDRESS <b>Annapolis, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 7 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13368

13379

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE	b. COUNTY						
RIVIERA BEACH		30 YEARS		MARYLAND	ANNE ARUNDEL						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
8442 GARDEN ROAD				X RIVIERA BEACH							
3. NAME OF DECEASED (Type or print)		First CATHERINE	Middle ANN	Last MARTINI	4. DATE OF DEATH DEC. 29 1960						
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Address				
FEMALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	AUG. 3, 1918							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
HOUSEWIFE			HOME		BALTO., MD.		U.S.A.				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
MILLARD F. DOWNEY				MARY A. GARDINER							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		219-16-4803		MRS. JUDY HENINGSEN		SAME					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA BREAST WITH METASTASES INTERVAL BETWEEN ONSET AND DEATH 11 months											
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)											
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY		Month, Day, Year	Hour a. m.	20d. INJURY OCCURRED	While at work <input type="checkbox"/>	Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
			p. m.	19							
21. I certify that I attended the deceased from FEB. 1960, to DEC. 29, 1960, that I last saw the deceased alive on DEC. 28, 1960, and that death occurred at 8305A M, from the causes and on the date stated above.								ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>J. Brady Smith</i>								M.D. 8471 Ft. Smallwood Road 12000			
PHYSICIAN'S NAME (Type) <i>J. Brady Smith</i>								PASADENA, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
Burial		Jan. 3, 1961		Glen Haven		H. H. County, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE								ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
<i>Frederick Cole</i>								1913 W. Belton St.	JAN 3 '61	<i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13408

## CERTIFICATE OF DEATH

Reg. Dist. No.

13369

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> 30 yrs.		c. LENGTH OF STAY IN 1b RURAL and give nearest town <b>Glen Burnie</b> 60				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box #440 Hanover Md.</b>		e. STREET ADDRESS <b>Box #440 Harmons Md.</b>				
3. NAME OF DECEASED (Type or print) <b>Theodore</b>		First <b>Matthews</b>	Middle Last			
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>July 15, 1907</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (State or foreign country) <b>Harmons Md.</b>			
13. FATHER'S NAME <b>Nicholas Matthews</b>		14. MOTHER'S MAIDEN NAME <b>Rossie Oliver</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>717-07-6750</b>	17. INFORMANT Address <b>Helen L. Matthews Box #440 Harmons Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  15/IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. { DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>  <b>Abdominal Carcinomatosis</b> <b>Carcinoma of Stomach</b> <b>5 mos.</b>				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>11</b>	20f. (City or town) <b>Seft. 30, 1960</b>	(County) <b>December 23rd 1960</b>	(State)
21. I certify that I attended the deceased from <b>Seft. 30, 1960</b> to <b>December 23rd 1960</b> , that last saw the deceased alive on <b>Dec. 23rd 1960</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE: <b>Frank E. Shipley</b> M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED <b>12/24/60</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/26/60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Sts Rest Cemetery</b>	22d. LOCATION (City, town, or county) <b>Harmons Maryland</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert E. Nutter-3035 W. North Ave.</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>DEC 27 1960</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur J. Shaffer</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13370

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY <i>A. A. CO</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville.</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Crownsville - State Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Robert (Robert) McCracken</i>		First <i>Robert</i>	Middle <i>(Robert)</i>
Last <i>McCracken</i>		4. DATE OF DEATH <i>12 25 1960</i>	Month Day Year
S. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>7-18-1900</i>
9. AGE (In years last birthday) <i>68 yrs.</i>		10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>Louis McCracken</i>	
14. MOTHER'S MAIDEN NAME <i>Mary</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>215-10-0640</i>		17. INFORMANT <i>Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subdural-Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Fracture - SKULL</i>			
DUE TO (b) <i>Fracture - SKULL</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Brain Syndrome associated w. Chronic alcoholism</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Unknown</i>		20c. TIME OF INJURY Month, Day, Year <i>before 12/16/ 1960</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Baltimore</i>	
20f. (City or town) (County) (State) <i>Baltimore Md.</i>		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .	
ACTUAL SIGNATURE <i>E. L. Winhardt</i>		DATE SIGNED <i>12/25/60</i>	
EXAMINER'S NAME (Type) <i>E. L. Winhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>12/28/60</i>		22b. DATE THEREOF <i>12/28/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Calvary</i>		22d. LOCATION (City, town, or county) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Halstead</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 3 '61</i>	
ADDRESS <i>7</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by me, it may be retained by the hospital or attending physician.  
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**13360**

**13371**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		b. COUNTY <b>Anne Arundel</b>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>1214 Summer Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>B.</b>	Last <b>McInnis</b>
4. DATE OF DEATH	Month <b>December</b>	Day <b>19</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-23-1880</b>
9. AGE (In years last birthday) <b>80 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Get SHOE SALESMAN</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>SHOE STORE</b>	11. BIRTHPLACE (State or foreign country) <b>CANADA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>SAMUEL McINNIS</b>	14. MOTHER'S MAIDEN NAME <b>ANN Mac DONALD</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>EMMA H. McINNIS</b>	Address <b>#2</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterial thrombosis</b> DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>3 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-15-1960</b> to <b>12-19-1960</b> , that (I) (we) last saw the deceased alive on <b>12-18-1960</b> , and that death occurred at <b>2:50 a.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank Shipley</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>12-18-60</b>
22c. PHYSICIAN'S NAME (Type) <b>Dr. Frank Shipley</b>		22d. ADDRESS <b>Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-20-60</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>BLOSSOM HILL</b>	23d. LOCATION (City, town, or county) <b>CONCORD N.H.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>John W. &amp; Sons Annapolis, Md.</b>	ADDRESS	25a. REC'D BY REGISTRAR DATE <b>DEC 23 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

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Environ Biol Fish (2007) 79:293–301

Efficiency

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*bioRxiv preprint doi:*

### Insects of Larvae of *Lathyrus sativus*

93

## Answers

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13410

## CERTIFICATE OF DEATH

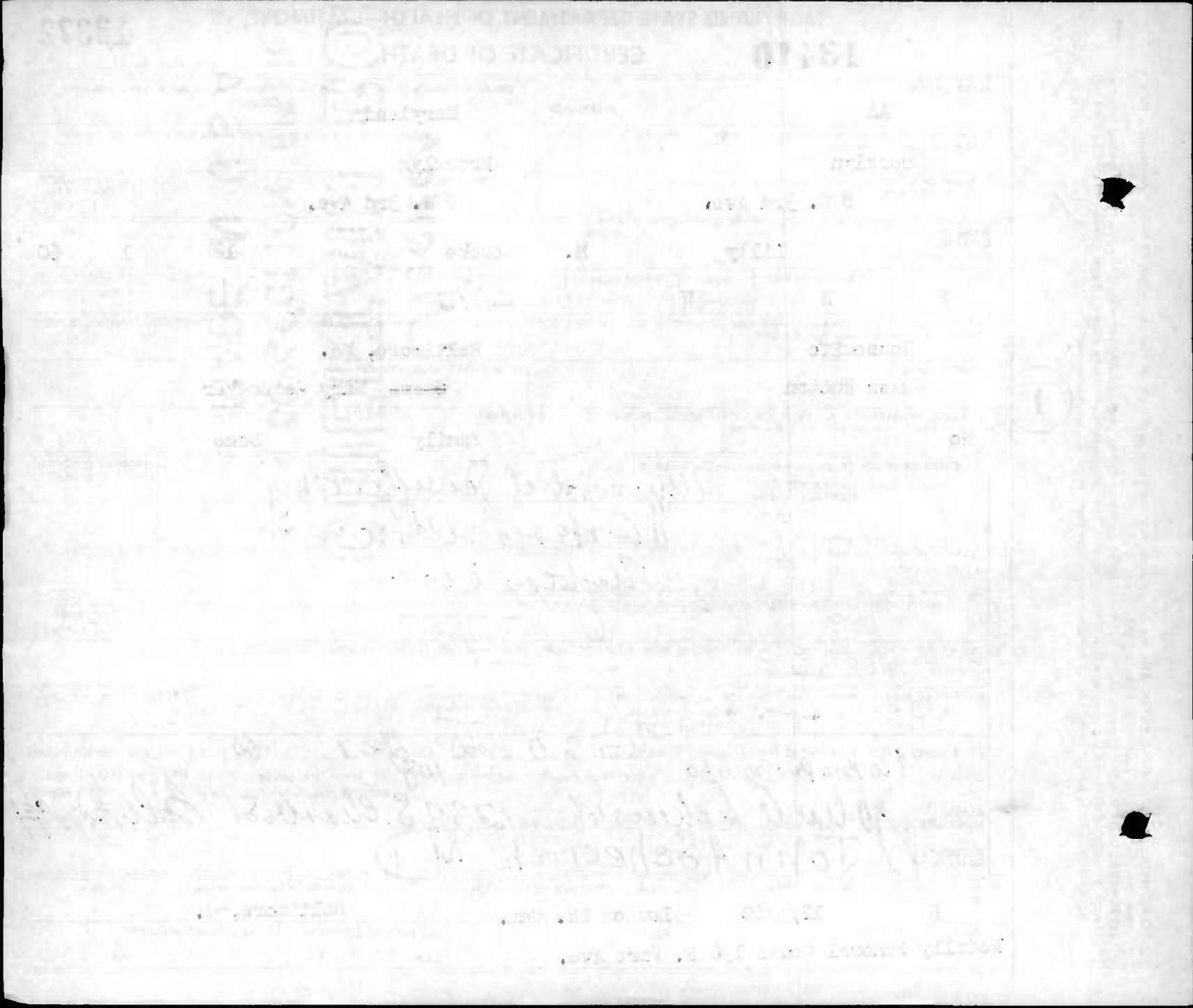
13372

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>		c. LENGTH OF STAY IN 1b <b>50</b> <b>Brooklyn</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 W. 3rd Ave.</b>		d. STREET ADDRESS <b>8 W. 3rd Ave.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Lilly</b>	Middle <b>M.</b>	Last <b>Meseke</b>	
4. DATE OF DEATH	Month <b>12</b>	Day <b>1</b>	Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/3/77</b>	
9. AGE (In years lost birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>83</b>	IF UNDER 24 HRS. Days <b>83</b>	Hours <b>83</b>	Min. <b>83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
13. FATHER'S NAME <b>James Hutton</b>		14. MOTHER'S MAIDEN NAME <b>James Mary Reinecker</b>		12. CITIZEN OF WHAT COUNTRY?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	INFORMANT <b>Family</b>	Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422</b> DUE TO <b>Hypocardial Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Cystic sclerosis →</b> (c) <b>Hypocarditis</b>				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>1</b>				
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>Nov</b>	Doy <b>23</b>	Year <b>1960</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/> 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b>Loudon Pk. Cem.</b>
20f. (City or town) <b>Baltimore, Md.</b>	(County) <b>Baltimore</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Nov 23, 1960</b> , to <b>Dec 1, 1960</b> , that I last saw the deceased alive on <b>November 30, 1960</b> , and that death occurred at <b>1150</b> M, from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>John A. Scheurich</i>	ADDRESS (Street, city or town, state) <b>M.D. 1337 S. Charles St. Baltimore, Md.</b>		DATE SIGNED <b>Dec 30, 1960</b>	
PHYSICIAN'S NAME (Type) <i>John A. Scheurich, M.D.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>	22b. DATE THEREOF <b>12/5/60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Pk. Cem.</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	(State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCullum Funeral Homes 130 E. Fort Ave.</b>		ADDRESS <b>McCullum Funeral Homes 130 E. Fort Ave.</b>	24a. REC'D BY REGISTRAR DATE <b>DEC 5 '60</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kirsch</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13411

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13373

1. PLACE OF DEATH  
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Severn

c. LENGTH OF STAY IN lb

4 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Box 233B Queenstown Rd.

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month  
December

Day  
18th.

Year  
1960

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

B. DATE OF BIRTH

9. AGE (In years  
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

F

C

Housework

WIDOWED  DIVORCED

9/21/15

Months  
45

Days  
yrs.

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Jacksonville, Fla.

USA

13. FATHER'S NAME

William Singletary

14. MOTHER'S MAIDEN NAME

Sally Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Emma Moses (sister).

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Coronary Occlusion

INTERVAL BETWEEN  
ONSET AND DEATH  
Sudden

420-1

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20e. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour e.m.  
p.m.

20d. INJURY OCCURRED  
White  Not White   
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)  
(County)  
(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL  
SIGNATURE

Gustave H. Faubert, M.D.

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S  
NAME (Type)

Gustave H. Faubert, M.D.

DEPUTY MEDICAL EXAMINER

12/18/60

Address (Street, city, town, or county)

22e. BURIAL, CREMATION  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

12/23/60

22c. NAME OF CEMETERY OR CREMATORIUM

Arbutus Mem. Pk.

22d. LOCATION (City, town or country)  
(State)

Arbutus, Md

23. FUNERAL DIRECTOR

ADDRESS

Joseph E. Locks Jr. 1304 N. Central St.

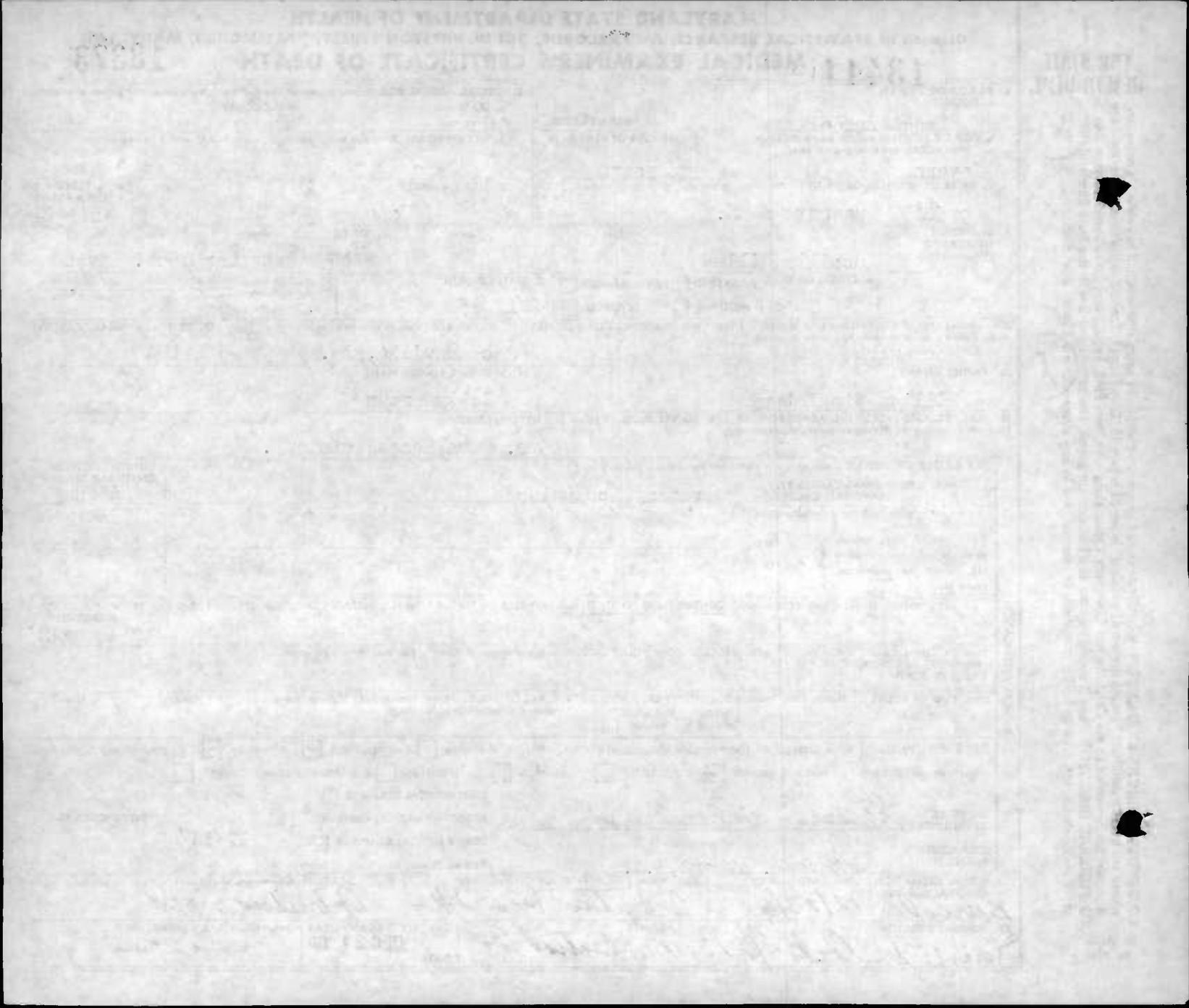
24a. REC'D BY REGISTRAR

DEC 21 '60

DATE

24b. REGISTRAR'S SIGNATURE

Arthur L. Thread



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13374

13412

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>3 mos. 8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>2216 Ruskin Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				4. DATE OF DEATH <b>12</b>		Month <b>28</b>	Day <b>19</b>	Year <b>60</b>						
3. NAME OF DECEASED (Type or print)	First <b>Harry</b>	Middle <b>Nelson</b>	Last	5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/21/85</b>	9. AGE (In years lost birthday) yrs. <b>75</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unempl. Pension</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Henry Nelson</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Gaither</b>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>212-32-1763</b>		17. INFORMANT <b>Hospital Records</b>		Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO <b>Heart Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Coronary Thrombosis</b>									INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Chronic Brain Syndrome associated with Arteriosclerosis</b>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----												
20c. TIME OF INJURY Month, Day, Year Hour ----- p. m. ----- 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) factory street office bldg. etc.		20f. (City or town) Johnsville		(County) Md.	(State) Md.					
21. I certify that (I) (this hospital) attended the deceased from <b>9/20</b> , 19 <b>60</b> , to <b>12/28</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> , 19 <b>60</b> , and that death occurred at <b>4:45 A.M.</b> , from the causes and on the date stated above.														
22a. SIGNATURE <i>L. Benedict, M.D.</i>		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>Dec 28, 1960</b>							
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>												
23a. BURIAL OR CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/31/60</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>St. Matthew's</b>		23d. LOCATION (City, town, or county) <b>JOHNSVILLE, Md.</b>		(State) Md.						
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law - 802 Madison Ave.</i>		ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 3 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>								
VR A15 1 (4) 1SM 9/59														

1000 ft

1000 ft

1000 ft

expansive layer 100 ft

silicate

interc. sandstone

interc. sandstone

sand

sand

100 ft

100 ft

light brown

yellowish

yellowish brown

greenish grey

greenish grey

yellowish brown

yellowish brown

yellowish

yellowish greenish

yellowish greenish

greenish greyish

charcoal, greenish

60

600 ft

600 ft

600 ft

basal rock, brownish sandy silicate

1  
FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13375

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Pasadena

c. LENGTH OF STAY IN 1b

Few seconds

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Bahama Beach

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Joseph Lee Patterson

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

b. STATE

Maryland

c. COUNTY

A.A.

d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Pasadena

e. STREET ADDRESS

1 Colonial Beach Drive

e. IS RESIDENCE  
ON A FARM?

YES  NO

Last

4. DATE  
OF  
DEATH

Month

Day

Year

December 14th,

19 60

5. SEX

6. COLOR OR RACE

M

W

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

July 8, 1902

9. AGE (In years  
last birthday)

58 yrs.

IF UNDER 1 YEAR

Months Dey

IF UNDER 24 HRS.

Hours Min.

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Taxi driver

10b. KIND OF BUSINESS OR INDUSTRY

Taxicab

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

Address

Alice I. Patterson | Colonial Beach Drive.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (e)

420, Coronary Occlusion

INTERVAL BETWEEN  
ONSET AND DEATH

Sudden

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(e), stating the underlying  
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20e. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour e.m.  
p.m.

20d. INJURY OCCURRED  
While Not While  
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

M.D. DEPUTY MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

12/15/60

ACTUAL  
SIGNATURE

Gustave H. Faubert, M.D.

22e. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

12/19/60

22c. NAME OF CEMETERY OR CREMATORI

Glen Haven Cemetery

22d. LOCATION (City, town, or country)

Glen Burnie Anne Arundel, Md.

(State)

23. FUNERAL DIRECTOR

Clemmons, Inc. 1528 Dulany Street, Bel.

ADDRESS

24e. REC'D BY REGISTRAR

DEC 20 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause

VS. A15ME  
5M 7/59

BP

RECORDED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE STATE OF COLORADO  
AT DENVER ON THE 1<sup>ST</sup> DAY OF MARCH, A.D. 1955.  
BY JAMES L. COOPER, CLERK.

L

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13376

13414

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

1. PLACE OF DEATH a. COUNTY <i>ANNE ARUNDEL</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PINE GROVE VILLAGE</i>		c. LENGTH OF STAY IN 1b <i>9 mos.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PASADENA 108-SANDY Beach PL.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pine Grove Village-Pasadena</i>	
d. STREET ADDRESS <i>PASADENA 108-Sandy Beach PL.</i>		f. STREET ADDRESS <i>PASADENA 108-Sandy Beach PL.</i>	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ANDREW</i>		First <i>E.</i>	Middle <i>PETERSON</i>
Last <i>PETERSON</i>		4. DATE OF DEATH <i>Dec. 25 1960</i>	Month Day Year
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Sept. 4 1879</i>		9. AGE (In years last birthday) <i>81 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RIGGER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem SHIPYARD</i>	
10c. FATHER'S NAME <i>PETERSON</i>		11. BIRTHPLACE (State or foreign country) <i>DENMARK U.S.A.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>DENMARK U.S.A.</i>			
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		14. MOTHER'S MAIDEN NAME <i>PETERSON</i>	
15. SOCIAL SECURITY NO. <i>213-03-284</i>		16. INFORMANT <i>CHARLES C. ALBAUGH</i>	
17. INFORMANT <i>SAME</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>	
DUE TO <i>420</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerotic heart disease</i>		DUE TO <i>10 yrs</i>	
(b)		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Senile Dementia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>2004 RITCHIE HIGHWAY</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>25 Dec. 1960</i> , to <i>25 Dec. 1960</i> , that I last saw the deceased alive on <i>25 Dec. 1960</i> , and that death occurred at <i>7:20 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Kehoe</i>		ADDRESS (Street, city or town, state) <i>GLEN BURNIE, MD.</i>	
PHYSICIAN'S NAME (Type) <i>John Kehoe</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>Dec. 29, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Meadow Ridge Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>PORCH, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard Evans &amp; Son</i>		ADDRESS <i>4005, 3rd Street</i>	
24a. REC'D BY REGISTRAR DATE <i>DEC 28 '60</i>		24b. REGISTRAR'S SIGNATURE <i>John E. Evans</i>	

## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

## CERTIFICATE OF DEATH

MD-1940

1940  
Date of Birth  
Place of Birth

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13377

**13415**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 15 yrs 7 mos. 12 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Harry	Middle	Last Plater			
4. DATE OF DEATH	Month 12	Day 7	Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1907	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alexander Plater			14. MOTHER'S MAIDEN NAME Marguerite Harvey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).  025X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Coronary Occlusion						
(b) Syphilitic & Arteriosclerotic Cardiovascular Disease DUE TO						
(c) General Paresis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. _____ p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr. 5, 1945, to Dec. 7, 1960, that (I) (we) last saw the deceased alive on Dec. 7, 1960, and that death occurred at 5:40 PM, from the causes and on the date stated above.						
22a. SIGNATURE <i>L. Benedict, M.D.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/> 22b. DATE December 8, 1960
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Crownsville State Hospital, Maryland				
23a. BURIAL CREMATION, REMOVAL (Specify) 12-10-60		23c. NAME OF CEMETERY OR CREMATORIAL H.I. Hope		23d. LOCATION (City, town, or county) Anne Arundel, Md. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE P. E. Sowell		ADDRESS P. Frederick, Md.		25a. REC'D BY REGISTRAR DATE DEC 15 '60		25b. REGISTRAR'S SIGNATURE C. King & Krause

Class

1907-1908



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

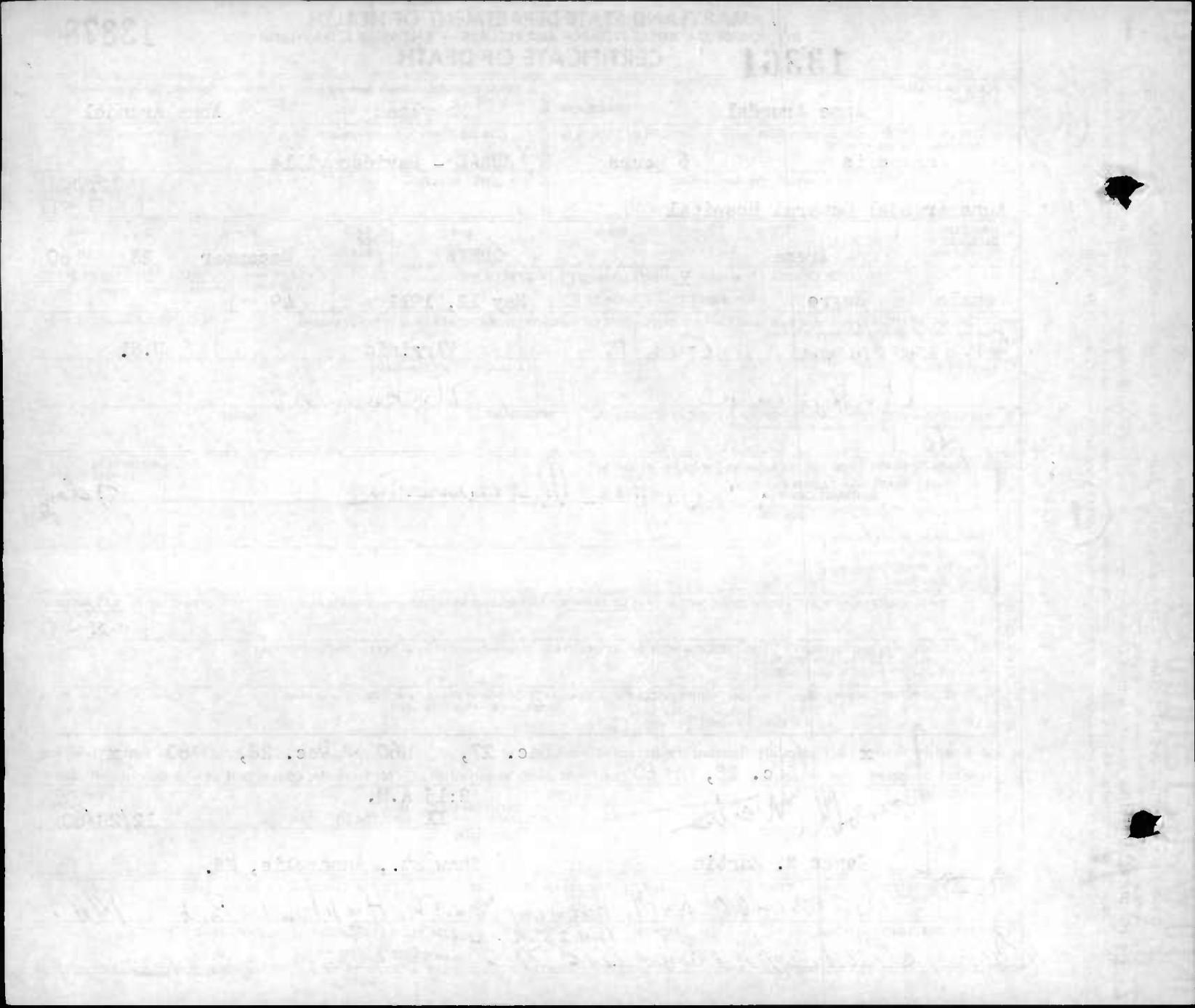
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13378

**CERTIFICATE OF DEATH**

13361

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>6 hours</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Maryland</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Davidsonville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>						d. STREET ADDRESS <b>1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Irene</b>		First		Middle		Last <b>QUEEN</b>		4. DATE OF DEATH <b>December 28 1960</b>		Month Day Year	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1911</b>		9. AGE (In years last birthday) <b>49 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Charwoman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>49ox</b> DUE TO <b>Sober Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>Dec. 27, 1960</b> , to <b>Dec. 28, 1960</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>Dec. 28, 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>James R. Martin</b>		M.D.		ATTENDING PHYS. <b>2:15 A.M.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/28/60</b>					
22c. PHYSICIAN'S NAME (Type) <b>James R. Martin</b>		22d. ADDRESS <b>6 Shaw St., Annapolis, Md.</b>									
23a. BURIAL OR CREMATION, REMOVAL (Specify) <b>12-31-60</b>		23b. DATE THEREOF <b>12-31-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Not 11, Harmony Mem. Pk. Highland Park</b>		23d. LOCATION (City, town, or county) <b>Held.</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Washington &amp; Sons Est. 1861 N.E.</b>		ADDRESS <b>4925 Cleverland</b>		REC'D BY REGISTRAR <b>1</b>		25b. REGISTRAR'S SIGNATURE <b>John S. Kline</b>					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13362

## CERTIFICATE OF DEATH

13379

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>76 Larkin St.,</b>	
3. NAME OF DECEASED (Type or print) <b>William Thomas Queen</b>		4. DATE OF DEATH <b>December 26 1960</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2 - 1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer -- City of Annapolis</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Elijah Queen</b>		14. MOTHER'S MAIDEN NAME <b>Lovy Woodhouse</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-1192A</b>	17. INFORMANT <b>Adele Parker - 405 Oaklawn Ave. Anna. Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443 X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		<b>Cerebral hemorrhage</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) <b>James R. Martin</b> attended the deceased from <b>Dec. 19, 1960</b> to <b>Dec. 25, 1960</b> , that (I) <b>lost</b> the deceased alive on <b>Dec. 25, 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>James R. Martin</b>	
22c. PHYSICIAN'S NAME (Type) <b>James R. Martin</b>		22b. DATE SIGNED <b>12/27/60</b>	22d. ADDRESS <b>6 Shaw St., Annapolis, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-29-60</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Brewer Hill</b>	23d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.E.Hicks III</b>		ADDRESS <b>Annapolis, Maryland</b>	25a. REC'D BY REGISTRAR DATE <b>JAN 4 '61</b>
			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>

all off

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13363

## CERTIFICATE OF DEATH

13380

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
<i>Anne Arundel MARYLAND</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Annapolis</i>		<i>Annapolis</i>	
d. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
		<i>5 Revell St.</i>	
e. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>5 Revell St.</i>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <b>HENRY</b>		Middle <b>DENISON</b>	Last <b>RANDALL</b>
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 20 1881</b>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years (last birthday)) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES MANAGER (RET) GEN. ELECTRIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LEDYARD CORN</b>	
11. BIRTHPLACE (State or foreign country) <b>LEDYARD CORN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JASON L. RANDALL</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA A. STODDARD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or date of service)		17. INFORMANT <b>HENRY D. RANDALL JR # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident at St. Remigius</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 days.</i>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)  DUE TO  (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypostatic pneumonia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>October</i> , 19 <i>60</i> , to <i>December</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Dec. 6</i> , 19 <i>60</i> , and that death occurred at <i>121 Cathedral St.</i> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>ANNAPOLIS MD.</i>	
ACTUAL SIGNATURE <i>John H. Hedeman</i>		DATE SIGNED <i>12/8/60</i>	
PHYSICIAN'S NAME (Type) <i>JOHN HEDEMAN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-10-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ledyard Center</b>		22d. LOCATION (City, town, or county) <b>Ledyard</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>JOHN M. TAYLOR Sons ANNAPOLIS MD.</i>		24a. REC'D BY REGISTRAR DATE DEC 9 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Khan</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retold by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13381

13416

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillerville RFD</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 yrs.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Foxwell Road, Elvaton</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Charles</i>	Middle <i>R.</i>	Last <i>Riddick</i>				
4. DATE OF DEATH <i>Dec. 4 1960</i>	Month	Day	Year				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10<sup>th</sup> Jan 1874</i>				
9. AGE (In years last birthday) <i>86</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>17</i>	12. IF UNDER 24 HRS. Hours <i>Glen Burnie, Md.</i>				
13. FATHER'S NAME <i>Rufus M. Riddick, Sr.</i>	14. MOTHER'S MAIDEN NAME <i>Margaret Roberts</i>	15. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mr. William Riddick</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i>	19. INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>				
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	20. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Congestive Heart Failure</i>	21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral Edema</i>	20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i></i>	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Dec. 19 1960</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>December 1960</i> to <i>December 1960</i> , that (I) (we) lost the deceased alive on <i>Dec. 3 1960</i> , and that death occurred of <i>4:40 M</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Ch McDonald MD</i>	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12-4-60</i>		
22c. PHYSICIAN'S NAME (Type) <i></i>	22d. ADDRESS <i></i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>25 Dec. 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ayden Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Ayden, N. Carolina</i>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>Richard V. Daington</i>	ADDRESS <i>Glen Burnie, Md.</i>	25a. REC'D BY REGISTRAR <i>DEC 6 '60</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>				

13410

16681

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

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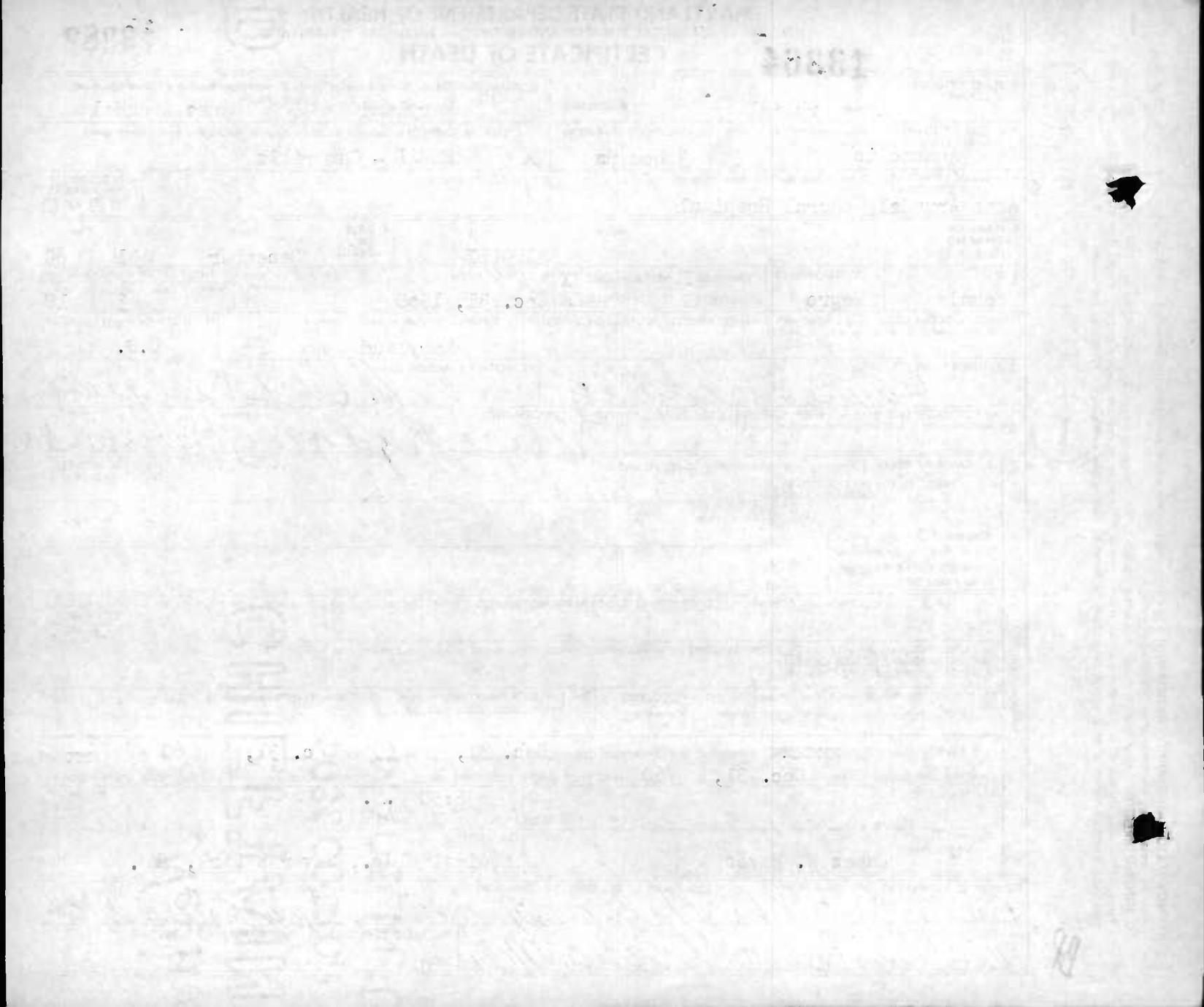
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

**13364**

**13382**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>3 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Lost		
4. DATE OF DEATH	Month	Day	Year		
<b>RIDGLEY</b>	<b>December</b>	<b>31</b>	<b>19 60</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31, 1960</b>		
9. AGE (In years last birthday) yrs. <b>3</b>	10. IF UNDER 1 YEAR Months <b>3</b>	11. IF UNDER 24 HRS. Days <b>10</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>James Ridgley</b>	14. MOTHER'S MAIDEN NAME <b>Alice Ridgley</b>	Address <b>Alice Ridgley Gambrills Md.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs 10 min</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) ( <b>James W. Hayes</b> ) attended the deceased from <b>Dec. 31, 1960</b> , to <b>Dec. 31, 1960</b> , that (I) <b>last</b> saw the deceased alive on <b>Dec. 31, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>James W. Hayes</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>8:50 P.M.</b>	
22c. PHYSICIAN'S NAME (Type) <b>James W. Hayes</b>			22d. ADDRESS <b>Medical Bldg., Severna Park, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-7-1961</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Wilson Cemetery Gambrills Md.</b>	23d. LOCATION (City, town, or county) <b>Gambrells Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese # Anna Md.</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>JAN 9 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be required by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13383

**13365**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel Co.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis, Md.</b>		c. LENGTH OF STAY IN 1b <b>60 Glen Burnie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL GEN HOSPITAL</b>		e. STREET ADDRESS <b>1571 Tieman Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Isabell M.</b>		First <b>R</b>	Middle <b>Oane</b>
4. DATE OF DEATH <b>12 25 1960</b>		Month <b>12</b>	Day <b>25</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Sept. 1891</b>		9. AGE (In years lost birthday) <b>69 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packet (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Noxema Corp.</b>	11. BIRTHPLACE (State or foreign country) <b>Fairfax Co., Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>(Unknown) Alexander</b>	
14. MOTHER'S MAIDEN NAME <b>Cora J. Thompson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>25-03-4225</b>		17. INFORMANT <b>Mrs. Grace E. Carey</b>	Address <b>Same As #2</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>550.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive arteriosclerotic C.-V. Disease 10 year</b>		(c) <b>Acute appendicitis, ruptured, generalized peritonitis 28 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Duodenal Ulcer, chronic. Chronic generalized arthriti's</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 28 1960</b> to <b>Dec. 25, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec. 25, 1960</b> , and that death occurred at <b>140 M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>12/25/60</b>	
22a. SIGNATURE <b>Merton T. Waite</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>1215 Cathedral St., Annapolis, Md.</b>
22c. PHYSICIAN'S NAME (Type) <b>Merton T. Waite</b>		23d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>28 Dec. 1960</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Woodlawn Cem. 60 Glen Burnie, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.V. Singleton</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 29 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

A.C.H. - N.Y. -

report

and 1900, 1901, 1902

and

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be repaired by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

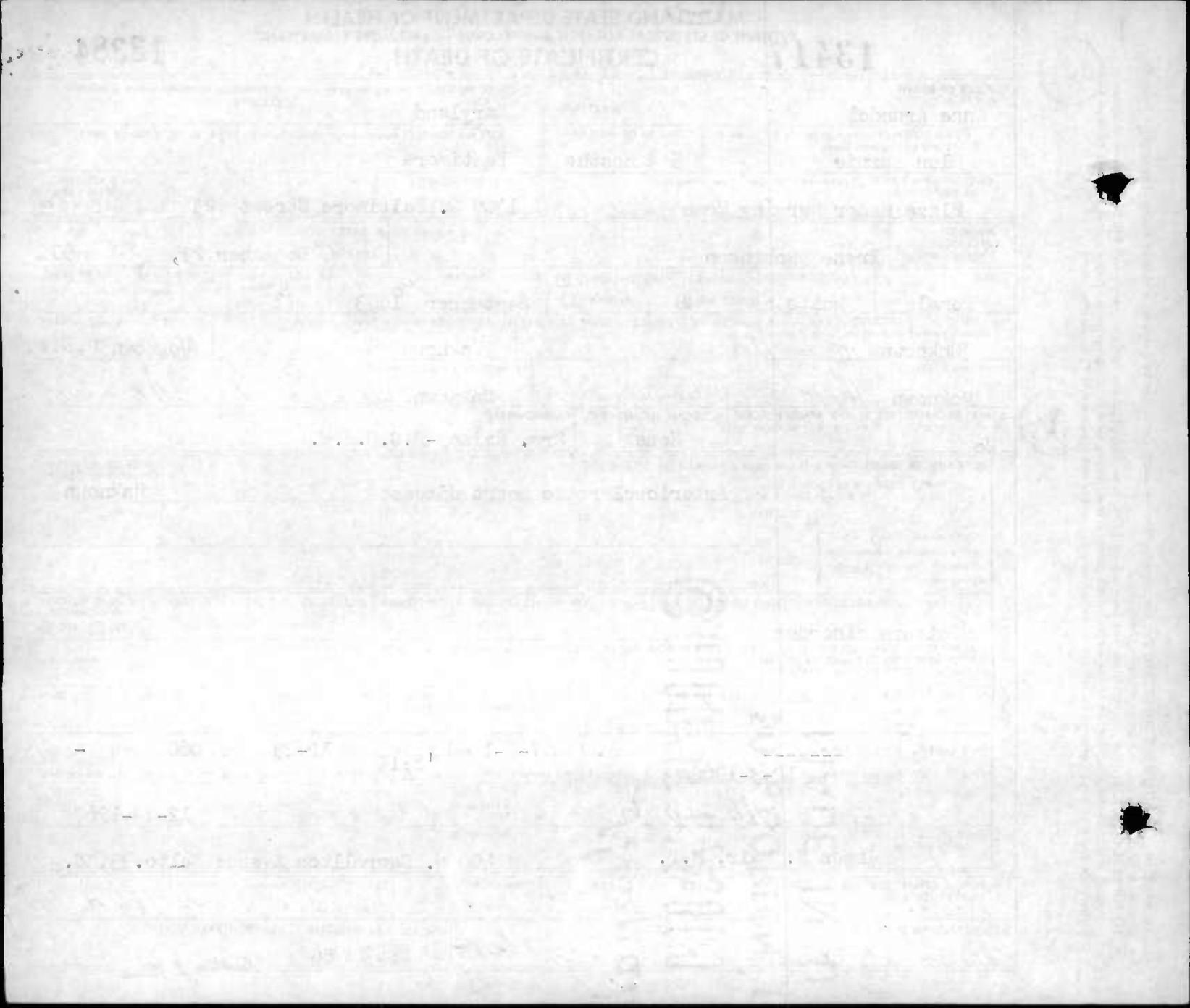
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13417

## CERTIFICATE OF DEATH

13384

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>5 ½ Months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1300 W. Baltimore Street 23</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Irene Robinson</b>		First	Middle	Last	4. DATE OF DEATH <b>December 23,</b>	Month	Day	Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>September 10, 1883</b>	9. AGE (In years last birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown U.S.A.</b>			
13. FATHER'S NAME <b>Unknown Thomas A. Kelly</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Irene E. Christmas</b>				Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Rainey-B.C.D.P.W.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <b>420.0</b>		DUE TO <b>(b)</b>		DUE TO <b>(c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Seizure disorder</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-8-1960</b> to <b>12-23-1960</b> , that (I) (we) lost saw the deceased alive on <b>12-3-1960</b> and that death occurred at <b>8:15 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>James M. Pair</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-23-1960</b>					
22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>		22d. ADDRESS <b>400 N. Carrollton Avenue Balto. 23, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>ADDRESS</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park Cem.</b>		23d. LOCATION (City, town, or county) <b>FREDERICK AVE. BETH. MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph N. Jeanneret Jr.</b>		ADDRESS <b>312 S. Highland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 27 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Trahan</b>			



1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>										Reg. Dist. No. 13385			
<b>CERTIFICATE OF DEATH</b>													
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deep Creek Rd.</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b> d. STREET ADDRESS <b>Deep Creek Rd.</b>								
3. NAME OF DECEASED (Type or print) <b>AMY LEE ROSS</b> First <b>AMY</b> Middle <b>LEE</b> Last <b>ROSS</b>					4. DATE OF DEATH <b>DECEMBER 11 1960</b> Month <b>Month</b> Day <b>Day</b> Year <b>Year</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 29, 1958</b>		9. AGE (In years lost birthday) <b>2 yrs.</b> IF UNDER 1 YEAR Months <b>0</b> Dots <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>					11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Robert B. Ross</b>					14. MOTHER'S MAIDEN NAME <b>Madolin Moreland</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or date of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>none</b>					17. INFORMANT <b>Mr. Robert B. Ross Father</b> same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>752</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b)</b> DUE TO <b>My degeneration and My decompensate</b> <b>Quiescent -</b> (c) <b>Birth</b>										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. <b>19</b> p. m.		Month <b>Month</b> <b>12/8</b>		Day <b>Day</b> <b>19/60</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>95 Calvert St</b>		20f. (City or town) <b>Annapolis, Maryland</b> (County) <b>Anne Arundel</b> (State) <b>Maryland</b>			
21. I certify that I attended the deceased from <b>10/29</b> , 19 <b>58</b> , to <b>12/11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12/8</b> , 19 <b>60</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Philip Briscoe</b> M.D.										ADDRESS (Street, city or town, state) <b>95 Calvert St</b> DATE SIGNED <b>12/15/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> <b>12-16-60</b>					22b. DATE THEREOF <b>12-16-60</b> 22c. NAME OF CEMETERY OR CREMATORIUM <b>Asbury Methodist Cemetery</b>					22d. LOCATION (City, town, or county) <b>Arnold, Maryland</b> (State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>					ADDRESS <b>Annapolis, Md.</b>					24a. REC'D. BY REGISTRAR <b>DEC 19 '60</b> DATE			
										24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

WILSON COUNTY TEXAS DEPARTMENT OF PUBLIC SAFETY  
CERTIFICATE OF DEATH

COPIES

10 COPIES

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by [REDACTED] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13366

## CERTIFICATE OF DEATH

13386

1. PLACE OF DEATH  
o. COUNTY

Anne Arundel

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Anne Arundel General Hospital

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

December 16

1960

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

1-12-1895

9. AGE (In years  
last birthday)  
yrs.

65

10. IF UNDER 1 YEAR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Auto Mechanic

10b. KIND OF BUSINESS OR INDUSTRY

R.R.

11. BIRTHPLACE (State or foreign country)

Texas

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Isaac J. Runyan

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Arthur J. Runyan

INTERVAL BETWEEN  
ONSET AND DEATH

1 month

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.

Hepatic failure

Cirrhosis of the Liver (Laennec's)

5 years

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

None

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year  
Hour a. m. p. m.

19

20d. INJURY OCCURRED

White Nat white  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 10/31 1960 to 12/16 1960, that (I) (REDACTED) last saw the deceased alive on 12/16 1960, and that death occurred at 7 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Richard L. Hockman

M.D. ATTENDING  
PHYS. MED  
DIRECTOR  STAFF  
PHYS. 22b. DATE  
SIGNED22c. PHYSICIAN'S  
NAME (Type)

Dr. R. L. Hockman

22d. ADDRESS

100 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

23b. DATE THEREOF

Dec 20-1960

23c. NAME OF CEMETERY OR CREMATORIAL

Bellcrest Cemt

23d. LOCATION (City, town, or county)

Annapolis

(State)

Md

24. FUNERAL DIRECTOR'S SIGNATURE

John W. Taylor Sons

ADDRESS

Annapolis Md.

25a. REC'D BY REGISTRAR

DEC 23 '60

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

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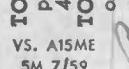
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1  
FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 13367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13387

Item 8 Film 6277 12-20-60 et

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>3451 Park Heights Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>MEYER</b>		4. DATE OF DEATH Last Month Day Year <b>December 12 19 60</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 5, 1915</b>	
9. AGE (In years last birthday) <b>45 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>T.V. Repair</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>W.S.A.</b>	
13. FATHER'S NAME <b>Isaac</b>		14. MOTHER'S MAIDEN NAME <b>Jennie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <b>A Helen Sacks - same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning.</b>		Address INTERVAL BETWEEN ONSET AND DEATH	
851X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Boat sunk.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>xx</b> p.m. <b>12/12/60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chesapeake Bay</b> 20f. (City or town) (County) (State) <b>Off Annapolis A.A. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>12/13/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-15-60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Mt Carmel</b>		22d. LOCATION (City, town, or county) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR <b>Jack Lewinick 2100 Eutaw Pl</b>		24a. REC'D BY REGISTRAR DEC 16 '60	
		24b. REGISTRAR'S SIGNATURE <b>Catherine S. Kline</b>	

БИБЛІОГРАФІЧНА  
ІНФОРМАЦІЯ

Інформація

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Інформація, яку ви маєте

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

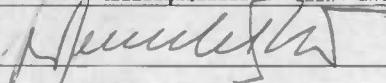
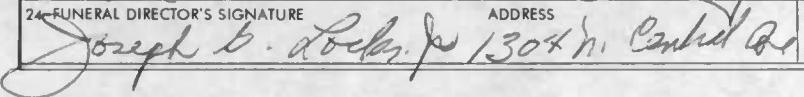
# MARYLAND STATE DEPARTMENT OF HEALTH

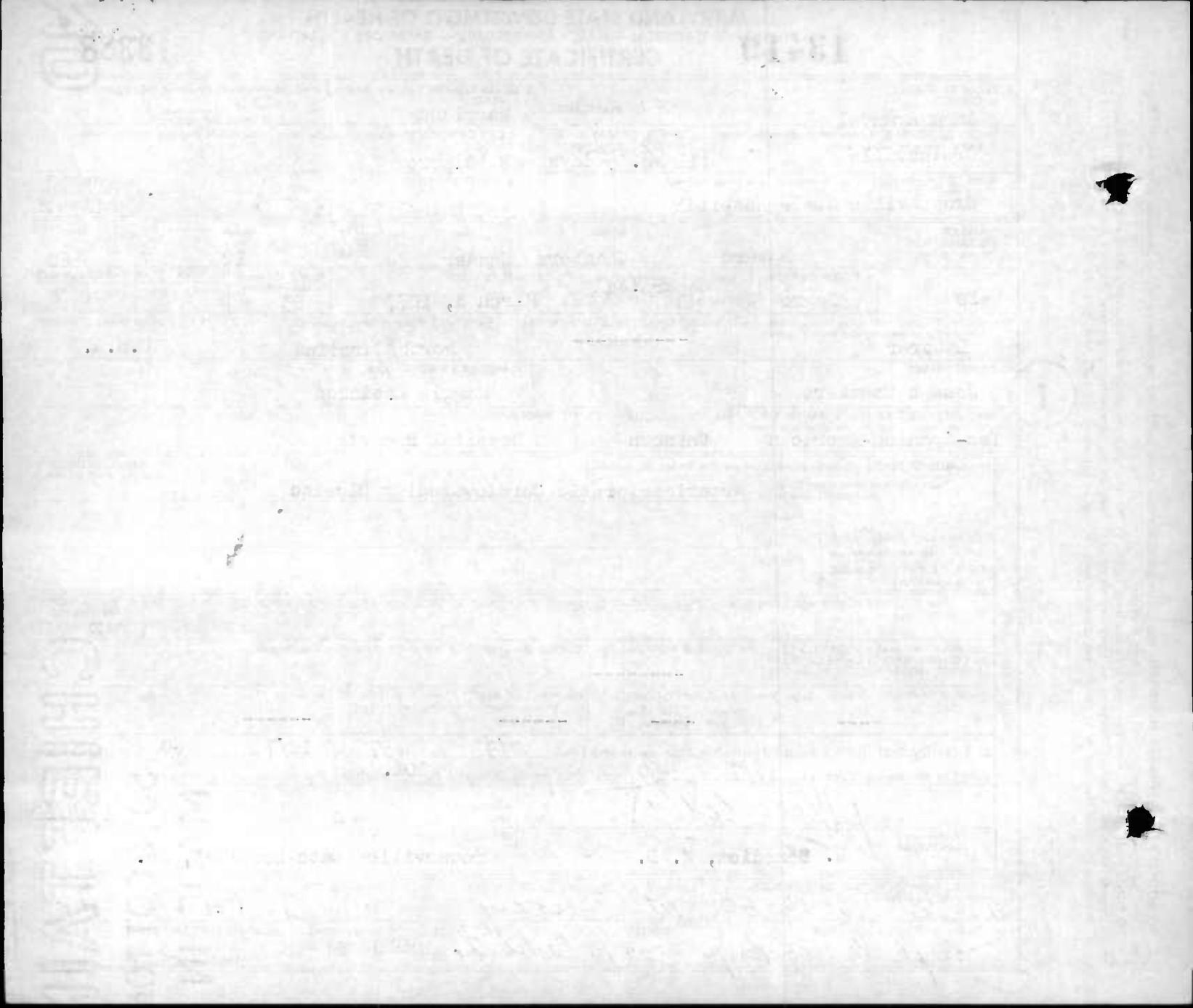
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13419

## CERTIFICATE OF DEATH

13388

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		b. COUNTY <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>2 years 11 mo. 5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>521 Bethel Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Edward</b>	Middle <b>Chambers</b>	Last <b>Sander</b>		
4. DATE OF DEATH	Month <b>12</b>	Day <b>7</b>	Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Separated</b>	8. DATE OF BIRTH <b>March 4, 1877</b>		
9. AGE (In years last birthday) <b>83 yrs.</b>	10. IF UNDER 1 YEAR Months <b>83</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Joseph Chambers</b>	14. MOTHER'S MAIDEN NAME <b>Maggie Robinson</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes-Spanish-American</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Hospital Records</b>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b>					
INTERVAL BETWEEN ONSET AND DEATH					
4/22/1 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____					
DUE TO					
(c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>			
20c. TIME OF INJURY Hour o. m. p. m. -----	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	20f. (City or town) <b>-----</b>	(County)	(State)
19					
21. I certify that (I) (this hospital) attended the deceased from <b>7/9</b> to <b>12/7</b> , 1960, that (I) (we) last saw the deceased alive on <b>12/7</b> , 1960, and that death occurred at <b>10A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE 		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/17/60</b>		
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-10-60</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Calvary</b>	23d. LOCATION (City, town, or county) <b>A. A. County, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS <b>1304 N. Central St.</b>	25a. REC'D BY REGISTRAR DATE <b>DEC 9 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13420 CERTIFICATE OF DEATH

13389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIVA</b>		c. LENGTH OF STAY IN 1b <b>X</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIVA</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIVA GUEST HOUSE</b>				d. STREET ADDRESS <b>NONE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ANNA SAULIT</b>		First	Middle	Last	4. DATE OF DEATH <b>DECEMBER 10 19 60</b>	Month	Day	Year	
5. SEX <b>Female</b> <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 5, 1887</b>	9. AGE (In years lost birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Latvia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Michael Bihnat</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr John E. Saulit Son</b>		Address <b>Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>174X</b>		DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b>		<i>Cervix &amp; the Uterus</i>		INTERVAL BETWEEN ONSET AND DEATH <b>295.</b>			
(b)		DUE TO <b>Metastasis to Intestinal Tract</b>							
(c)		DUE TO <b>fever</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis - Carbo Vascular Disease</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, grocery, street, office bldg., etc.) <b>Death in bed</b>		20f. (City or town) <b>Towson</b>		(County) <b>Baltimore</b>	(State) <b>Md.</b>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>Dec. 10 1960</b>									
21. I certify that I attended the deceased from <b>Dec. 10, 1960</b> to <b>Dec 10, 1961</b> , that I last saw the deceased alive on <b>Dec. 10, 1960</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Albert L. Anderson</i>						ADDRESS (Street, city or town, state) <b>Southgate Ave, Annapolis, Maryland</b>		DATE SIGNED <b>12/14/61</b>	
PHYSICIAN'S NAME (Type) <b>Albert L. Anderson MD.</b>		22b. DATE THEREOF <b>Dec. 16-1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>All Hallows Cemetery</b>		22d. LOCATION (City, town, or county) <b>Davidsonville, Md.</b>		(State)	
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hopping</i>		ADDRESS <b>Hopping Funeral Home Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 19 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knott</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

DEATH CERTIFICATE  
NAME OF DECEASED: **JOHN J. HANNAH**  
SEX: **M** BIRTH DATE: **1870**  
MATERIAL TESTIMONY:  
I, **JOHN J. HANNAH**, do solemnly declare and say that I am the deceased named above, and that I died on the **10th day of January, 1900**, at the age of **29 years**.  
I further declare that I was born in the State of **Massachusetts**, and that I resided in the city of **Boston**, State of **Massachusetts**, during my life.  
I further declare that I was married to **MARY E. HANNAH**, and that we were living together at the time of my death.  
I further declare that I was a **blacksmith** by occupation, and that I was employed at the time of my death.  
I further declare that I was a member of the **Methodist Church**, and that I was buried in the **Methodist Cemetery**.  
I further declare that I was a **blacksmith** by occupation, and that I was employed at the time of my death.  
I further declare that I was a member of the **Methodist Church**, and that I was buried in the **Methodist Cemetery**.

TESTIMONY:  
I, **JOHN J. HANNAH**, do solemnly declare and say that I am the deceased named above, and that I died on the **10th day of January, 1900**, at the age of **29 years**.  
I further declare that I was born in the State of **Massachusetts**, and that I resided in the city of **Boston**, State of **Massachusetts**, during my life.  
I further declare that I was married to **MARY E. HANNAH**, and that we were living together at the time of my death.  
I further declare that I was a **blacksmith** by occupation, and that I was employed at the time of my death.  
I further declare that I was a member of the **Methodist Church**, and that I was buried in the **Methodist Cemetery**.  
I further declare that I was a **blacksmith** by occupation, and that I was employed at the time of my death.  
I further declare that I was a member of the **Methodist Church**, and that I was buried in the **Methodist Cemetery**.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13421

13390

Items 1, 2 FilmG278 1-5-61 et 3V014

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Baltimore, Md.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. LENGTH OF STAY IN 1b 3 Mos. 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville, Md.</i> d. STREET ADDRESS <i>3316 Auchentoroly Ter.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville State</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>W</i>	Last <i>Saunders</i>	4. DATE OF DEATH Month <i>12</i> Day <i>24</i> Year <i>1960</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-24-77</i>		9. AGE (In years at birthday) <i>83</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waiter</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Richard Gray</i>		14. MOTHER'S MAIDEN NAME <i>—</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Medical Record - Crownsville, Md.</i> Address <i>Crownsville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac &amp; Respiratory failure</i> DUE TO <i>Extreme old age</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <i>Since admission</i> (c)					
INTERVAL BETWEEN ONSET AND DEATH <i>8-10 hrs</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>CHRONIC BRAIN SYNDROME ASSOCIATED w/ GENERALIZED ARTERIOSCLEROSIS</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>—</i>	
21. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that death occurred at _____ M, from the causes and on the date stated above.					
22a. SIGNATURE <i>L. Benedict, M.D.</i>		M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>—</i>	
22c. PHYSICIAN'S NAME (Type) <i>L. Benedict, M.D.</i>		22d. ADDRESS <i>Crownsville State Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-28-60</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>arbitus</i>	23d. LOCATION (City, town, or county) <i>md</i> (State) <i>—</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Geo. S. Kelson 1348 N. Calhoun St</i>		ADDRESS <i>Geo. S. Kelson 1348 N. Calhoun St</i>	25a. REC'D BY REGISTRAR DATE DEC 27 '60		25b. REGISTRAR'S SIGNATURE <i>— 8 hours</i>

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG276 12-9-60 at

13391

13422

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shipley, Maryland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shipley</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i>Shipley Farm</i>	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
f. LENGTH OF STAY IN 1b <i></i>		Fairmount Road	
3. NAME OF DECEASED (Type or print) <i>Irene</i>		First <i>Amanda</i>	Middle <i>Shipley</i>
4. DATE OF DEATH <i>December</i>	Month <i>2,</i>	Day <i>19</i>	Year <i>60</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>July 1, 1875</i>
9. AGE (In years last birthday) <i>85 yrs.</i>		10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Schoolteacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Shipley, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richard Luther Shipley</i>		14. MOTHER'S MAIDEN NAME <i>Annie S. Linthicum</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. J. Clinton Roberts</i>		Address <i>Fairmount Road</i>	
		<i>Shipley, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cardiovascular Disease</i>		54 years	
DUE TO <i></i>			
DUE TO <i></i>			
DUE TO <i></i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) <i></i>	
		(State) <i></i>	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 10:30A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i></i>			
DATE SIGNED <i></i>			
ACTUAL SIGNATURE <i>James S. Bellinger</i>		M.D. 108 Carter Ave Glen Burnie Md	
PHYSICIAN'S NAME (Type) <i>James S. Bellinger</i>		108 Carter Ave Glen Burnie Md Dec 5, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/5/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park Cemetery</i>
		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ken Luckner Sons Inc</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 6 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

13392

13423

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Hgts.</b>	c. LENGTH OF STAY IN 1b <b>5 yrs.</b>	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Brooklyn Hgts.</b>			a. COUNTY <b>Anne Arundel</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4950 Brookwood Road</b>			d. STREET ADDRESS <b>4950 Brookwood Road</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Ella Madeline Sheres</b>		First <b>Ella</b>	Middle <b>Madeline</b>	Last <b>Sheres</b>	4. DATE OF DEATH <b>Dec. 16, 1960</b>			
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 31, 1902</b>	9. AGE (In years lost birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months <b> </b>	IF UNDER 24 HRS. Days <b> </b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>John Railey</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Marshall</b>			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mr. William B. Sheres Same</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>420.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic Heart Disease</b> DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Diabetes Mellitus</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>Jan. 15, 1955</u> to <u>Dec. 15, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec. 15, 1960</u> , and that death occurred at <u>3 a.m.</u> from the causes and on the date stated above.								
22a. SIGNATURE <b>Dr. Berdann</b>				ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>Dec. 16,</b>	
22c. PHYSICIAN'S NAME (Type) <b>BENJAMIN BERDANN</b>				22d. ADDRESS <b>5010 A. Gov. Ritchie Hwy.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 19, 1960</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Ritchie Hwy. A. A. Co., Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Jones</b>				ADDRESS <b>4001 Ritchie Hwy. (25)</b>		25a. REC'D BY REGISTRAR <b>DEC 21 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Carroll &amp; Sons</b>	

SECRET

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13368 CERTIFICATE OF DEATH

Reg. Dist. No.

13393

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis,</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		d. STREET ADDRESS <b>14 N. Brewer Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 N. Brewer Ave.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY I SMITH</b>		First	Middle	Last	4. DATE OF DEATH <b>DECEMBER 8</b>	Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 26, 1879</b>	9. AGE (In years lost birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13. FATHER'S NAME <b>George Hayman</b>				14. MOTHER'S MAIDEN NAME <b>Mary Mariner</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Walter B. Smith Sr. Husband</b>		Address <b>same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>33 IX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senility</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>olive</b>							
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. <b>Dec. 8, 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>5 Shaw Street, Annapolis, Maryland</b>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec. 8, 1960</b> to <b>Dec. 8, 1960</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>James R. Martin</b>						ADDRESS (Street, city or town, state) <b>Annapolis, Maryland</b>			
22. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 12, 1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Annapolis National Cemetery</b>		22d. LOCATION (City, town, or county) <b>Annapolis, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur G. Hopping</b>		ADDRESS <b>Hopping Funeral Home</b>		24a. REC'D BY REGISTRAR <b>Arthur G. Hopping</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur G. Hopping</b>			
VS AIS (4) 1SM 10/57				DATE <b>DEC 19 '60</b>					

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13369

CERTIFICATE OF DEATH

13394

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Beach</b>		d. STREET ADDRESS <b>9th. and Dayton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Leroy</b>	Middle <b>O.</b>	Last <b>Soper</b>	4. DATE OF DEATH	Month <b>12</b>	Day <b>2</b>	Year <b>1960</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>7-20-97</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS. Days <b>16</b>	Hours <b>56</b> Min.
8. WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GAS STATION</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Owen Soper</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Cranford</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16. SOCIAL SECURITY NO. <b>W. W. I</b>		17. INFORMANT <b>Mrs. Leroy Soper, North Beach, Maryland</b>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>204.0</b>			BRONCHO PNEUMONIA INTERVAL BETWEEN ONSET AND DEATH <b>5-16-56</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LYMPHATIC LEUKEMIA</b>			DUE TO <b>5Y</b>				
(c)			DUE TO <b>7mo</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>1960</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-16</b> 19 <b>56</b> to <b>12-2</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>12-2</b> 19 <b>60</b> , and that death occurred at <b>97M</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edith Rodler</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12-3-60</b>
22c. PHYSICIAN'S NAME (Type) <b>Dr. Edith Rodler</b>		22d. ADDRESS <b>Franklin Street, Annapolis, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 6, 1960</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Emmanual Church Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Plum Point, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hutchins Funeral Home</b>		ADDRESS <b>Owings, Maryland</b>		25a. REC'D BY REGISTRAR DATE DEC 7 '60		25b. REGISTRAR'S SIGNATURE <b>Charles S. Thoms</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13395

## 13424 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brownsville</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Brownsville X</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Tela</i>	Middle <i>Stansbury</i>	Last 4. DATE OF DEATH Month 12 - Day 9 Year 1960
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-27-1903</i>
9. AGE (In years lost birthday) yrs. <i>57</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) <i>Maryland U.S.A.</i>
13. FATHER'S NAME <i>Joshua</i>	14. MOTHER'S MAIDEN NAME <i>Alaland</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.
17. INFORMANT <i>William Stansbury, Brownsville</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>592X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	INTERVAL BETWEEN ONSET AND DEATH <i>About 2 yr</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>F 5054</i>	20f. (City or town) (County) (State) <i>12-10666</i>
21. I certify that I attended the deceased from <i>12-8-60</i> , 19, to <i>12-10666</i> , 19, that I last saw the deceased alive on <i>12-8-60</i> , 19, and that death occurred at <i>62 Cochran St</i> , M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>G.T. Cole</i> M.D. ADDRESS (Street, city or town, state) <i>62 Cochran St</i> DATE SIGNED <i>12-14-60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-13-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>	22d. LOCATION (City, town, or county) <i>St Margaret Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reeset Funeral Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>DEC 19 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13376

13396

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Odenton

c. LENGTH OF STAY IN lb

?

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Annapolis Rd. (Doom Town)

3. NAME OF  
DECEASED  
(Type or print)

First  
Last

2 Middle

Daniel

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

White

WIDOWED

DIVORCED

8. DATE OF BIRTH

28th June 1915

Month

Day

Year

9. AGE (In years  
less birthday)

45 yrs.

IF UNDER 1 YEAR

Months Days

Hours Min.

19 60

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired army man

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Highland Township, Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

H. Russell Stoops

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give rank or date of service)

Yes

W.W. II

16. SOCIAL SECURITY NO.

unknown

17. INFORMANT

Mr. H. Russell Stoops, Gettysburg, R.D.2

Address

Pa.

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (e)

Asphyxiation by smoke

DUE TO

(b)

Conditions, if any, which  
gave rise to immediate cause  
(e), stating the underlying  
cause last.

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

Few minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20e. EXTERNAL CAUSE WAS  
PRIMARY OR CONTRIBUTING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour e.m. 4.15 A.M.

p.m. 12/19/60

20d. INJURY OCCURRED While Not While

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

Annapolis Rd. Odenton, Md. A.A. County.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Gustave H. Faubert, M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

12/19/60

Glen Burnie, Md.

Address (Street, city, town, or county)

22e. BURIAL, CREMATION  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

12/22/60

22c. NAME OF CEMETERY OR CREMATORIAL

Fairfield Union

22d. LOCATION (City, town, or country)

Fairfield, Adams Co., Pa.

23. FUNERAL DIRECTOR

C. E. Wilson

ADDRESS

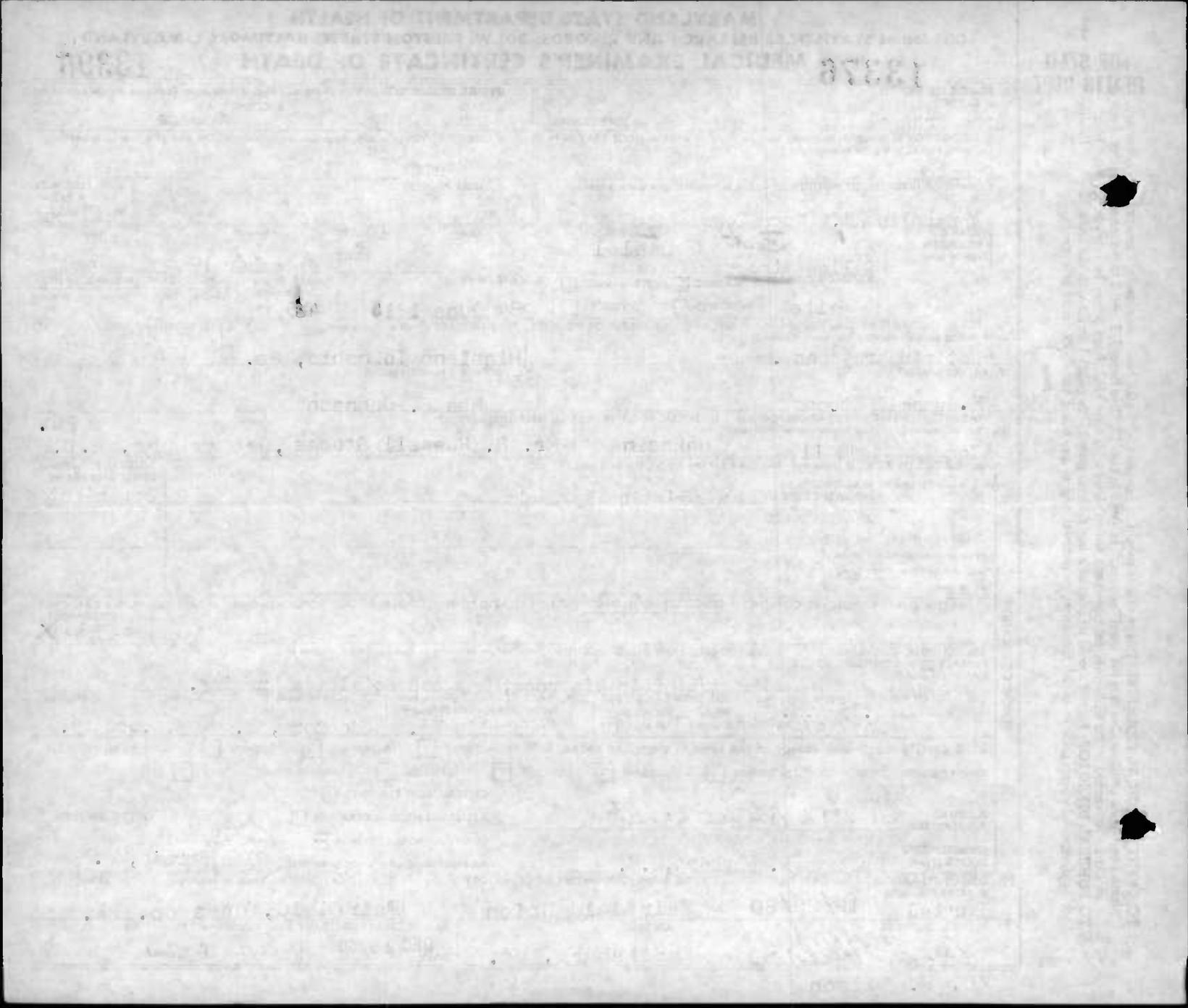
Emmitsburg, Md.

24e. REC'D BY REGISTRAR

DEC 23 '60

DATE

Arthur S. Kraus



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar. Do not bury or cremate.

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VS. A15ME(5)  
5M 9/55  
hours

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13370 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13397

1. PLACE OF DEATH a. COUNTY <b>A. A. Co.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	c. LENGTH OF STAY IN lb	b. COUNTY <b>A. A. Co.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODLAND BEACH X</b>
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>H. A. GENERAL Hospital</b>		d. STREET ADDRESS <b>3514 SALISBURY RD</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>John ROBERT Storms</b>	First	Middle	Last
4. DATE OF DEATH	Month <b>12</b>	Day <b>29</b>	Year <b>1960</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1960</b>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) <b>1 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ALFRED W. Storms</b>		14. MOTHER'S MAIDEN NAME <b>MARGIE JACK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>ALFRED W. Storms</b>		Address <b># 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X</b> DUE TO <b>Pneumonia</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b>			
DUE TO (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>o. m.</b> <b>p. m.</b>	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>E. Linhardt</b>	DATE SIGNED <b>12/29/60</b>		
EXAMINER'S NAME (Type) <b>E. Linhardt</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12-29-60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>HILLCREST</b>	22d. LOCATION (City, town, or county) <b>Annapolis</b> (State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Bryant Sons Annapolis, Md.</b>	ADDRESS <b>—</b>	24a. REC'D BY REGISTRAR <b>Arthur S. Thomas</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>
		DATE <b>JAN 3 '61</b>	

CUT

RECORDED IN THE OFFICE OF THE CLERK OF THE STATE OF TEXAS  
ON THE 22ND DAY OF JUNE, 1900.

THE 22ND

JUN 22

1900



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13425

13398

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH

a. COUNTY  
**Anne Arundel**

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

**Crownsville**

c. LENGTH OF STAY IN lb  
**7 mos. 15 days**

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION  
**Crownsville State Hospital**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE  
**Maryland**

b. COUNTY  
**Baltimore City**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

**Baltimore 31**

2 VOL - 4

d. STREET ADDRESS

**30 S. Register Street**

e. IS RESIDENCE  
ON A FARM?  
YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First  
**Julia**

Middle

Last  
**Walters**

4. DATE  
OF  
DEATH

Month  
**12**

Day  
**7**

Year  
**1960**

5. SEX

**Female**

6. COLOR OR RACE

**Negro**

7. MARRIED  NEVER MARRIED

WIDOWED

8. DATE OF BIRTH

**1888**

9. AGE (In years  
last birthday)  
yrs.

**72**

IF UNDER 1 YEAR IF UNDER 24 HRS.  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

**Packing House**

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Virginia**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Unknown**

14. MOTHER'S MAIDEN NAME

**Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

**No**

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

**Unknown**

17. INFORMANT

**Hospital Records**

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

**Bronchopneumonia**

INTERVAL BETWEEN  
ONSET AND DEATH

491X  
Conditions, if any, which  
give rise to immediate  
cause (a), stating the under-  
lying cause lost.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

**Cerebral Arteriosclerosis Associated with Cerebral Hemorrhage**

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING  CAUSE OF DEATH  
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month Day Year  
Hour o. m. \_\_\_\_\_ p. m. \_\_\_\_\_

20d. INJURY OCCURRED  
While at work  Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from **April 22 1960** to **December 7 1960**, that (I) (we) last saw the deceased alive on **December 7 1960**, and that death occurred at **1 P:55** from the causes and on the date stated above.

22a. SIGNATURE

**S. Benedict**

M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22b. DATE  
SIGNED  
**12/8/60**

22c. PHYSICIAN'S  
NAME (Type)

**L. Benedict, M. D.**

22d. ADDRESS

**Crownsville State Hospital, Maryland**

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE THEREOF  
**12/16/60**

23c. NAME OF CEMETERY OR CREMATORIUM  
**V of Maryland**

23d. LOCATION (City, town, or county)  
**Baltimore, Md.**

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

**William Reese**

ADDRESS

25a. REC'D BY REGISTRAR  
**DEC 21 '60**

25b. REGISTRAR'S SIGNATURE  
**Arthur S. Kraus**

QUEL

PARIS FRANCE STAMP COLLECTOR



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by [redacted] (funeral director), page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

13399

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>1 mo. 28 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
f. STREET ADDRESS <b>122 O'Berry Court</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Sadie</b>	Middle <b>Isabella</b>	Last <b>Warfield</b>
4. DATE OF DEATH	Month <b>12</b>	Day <b>15</b>	Year <b>1960</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1921</b>
9. AGE (In years at birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Henry Moore</b>	14. MOTHER'S MAIDEN NAME <b>Laura Madison</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, unknown] <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Hospital Records</b>	Address <b>Frank Warfield/22 O'berry Ct.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Hypostatic</b>			
443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Old Cerebral Vascular Accident</b>			
(c) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----	20d. INJURY OCCURRED While <input type="checkbox"/> Not at <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) <b>Dec. 15</b> (County) <b>1960</b> (State) <b>MD</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 17</b> to <b>Dec. 15</b> , 1960, that (I) (we) last saw the deceased alive on <b>Dec. 15</b> , 1960, and that death occurred at <b>MD</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>William Rees &amp; Ann Md.</b>	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/15/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. Benedict, M. D.</b>	22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/18/60</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Brewerville</b>	23d. LOCATION (City, town, or county) <b>Anne Arundel</b> (State) <b>MD</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Williams Rees &amp; Ann Md.</b>	ADDRESS <b>111 W. Main St.</b>	25a. REC'D BY REGISTRAR DATE <b>DEC 19 1960</b>	25b. REGISTRAR'S SIGNATURE <b>Carmer &amp; Thorne</b>

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olivaceo, olivaceo, simeon

olivaceo

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olivasi

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 will be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13400

13371

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>13 Tucker Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Hilda</b>	Middle <b>W.</b>	Last <b>White</b>	4. DATE OF DEATH	Month <b>December</b>	Day <b>24,</b>	Year <b>19 60</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug - 26 - 1901</b>	9. AGE (In years lost birthday) <b>59 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done)		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank J. Linhardt</b>		14. MOTHER'S MAIDEN NAME <b>McKinnon</b>		Address <b>Arthur P. White</b>		(2)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>	
(If yes, give war or dates of service)						<b>Unknown</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b>							
33 IX DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSION</b>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>DEC 20 1960</b> to <b>DEC 24 1960</b> , that (I) ( <del>were</del> last saw the deceased alive on <b>December 24 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edward S. Beck</b>		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>Dr. Edward S. Beck</b>		22d. ADDRESS <b>Franklin Street</b>		Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 28-1960</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Annapolis National</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Scyler Sims</b>		ADDRESS <b>Annapolis Md</b>		25a. REC'D BY REGISTRAR <b>DEC 28 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

1115

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lemonade

1  
FOR STATE  
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13372 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13401

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mayo</b>		d. STREET ADDRESS <b>Box 48</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>DOA Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Gladys Barrow</b>		First	Middle	Last	4. DATE OF DEATH <b>December 20 1960</b>	Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1899</b>	9. AGE (In years last birthday) <b>61 yrs.</b>	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Alfred Barrow</b>				14. MOTHER'S MAIDEN NAME <b>Alma Harding</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> NO!		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr Robert I Williams Jr.</b>		Address <b>same as # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>350X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH <b>Cardiac</b> <b>Fallen</b> <b>Parkinson Disease</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)									
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. Linhardt</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>12. 20. 60.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 23, 1960</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington, National Cemetery</b>	22d. LOCATION (City, town, or county) <b>Arlington, Va.</b>	(State)				
23. FUNERAL DIRECTOR <i>Hopping</i>		ADDRESS <b>Hopping Funeral Home</b>	24e. REC'D BY REGISTRAR <b>DEC 27 '60</b> 24f. REGISTRAR'S SIGNATURE <i>Arthur S. Tracy</i>						
VS. A15ME 5M 7/59									



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rebilled by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										13403							
13428 CERTIFICATE OF DEATH																	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>					c. LENGTH OF STAY IN 1b <b>6 days</b>					b. COUNTY <b>Baltimore City</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> First <b>Robert</b> Middle <b>L.</b> Last <b>Williamson</b> (Type or print)					<b>4. DATE OF DEATH</b> <b>12 2 1960</b>					Month	Day	Year					
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April, 1935</b>					9. AGE (In years lost birthday) <b>25</b> yrs.	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>					11. BIRTHPLACE (State or foreign country) <b>Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Hezekiah Williamson</b>					14. MOTHER'S MAIDEN NAME <b>Eloise White</b>												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-30-3617</b>			17. INFORMANT <b>Hospital Records</b>			Address									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]													INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>300.7</b> DUE TO <b>Bronchopneumonia</b>																	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Schizophrenia</b> (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) -----													19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----														
20c. TIME OF INJURY Month, Doy, Year Hour o. m. --- p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----			20f. (City or town) ----- (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <b>11/26 1960</b> to <b>12/2 1960</b> , that (I) (we) lost saw the deceased alive on <b>12/2 1960</b> , and that death occurred at <b>P.M.</b> , from the causes and on the date stated above.																	
22o. SIGNATURE 							M.D. <input type="checkbox"/> ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/> <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/3/60</b>							
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>							22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>										
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12-7-60</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Calvary Cem.</b>			23d. LOCATION (City, town, or county) <b>A.A.C. Md.</b>			(State)					
24. FUNERAL DIRECTOR'S SIGNATURE 							ADDRESS <b>1011-13 N. Arlington Av.</b>			25a. REC'D BY REGISTRAR <b>DEC 7 '60</b>		25b. REGISTRAR'S SIGNATURE 					

0 1 4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by you, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13404

1. PLACE OF DEATH a. COUNTY <i>Oceneawell Co</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mulberryville</i>		c. LENGTH OF STAY IN 1b <i>5 1/2 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Knollwood Manor</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Jacob R. Woodring</i>		First <i>J</i>	Middle <i>R.</i>
4. DATE OF DEATH <i>12/15/60</i>		5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/21/1876</i>	
9. AGE (In years last birthday) <i>84</i>		10. IF UNDER 1 YEAR Months <i>12</i>	11. IF UNDER 24 HRS. Months Days Hours Min. <i>15 00 00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Waynesboro</i>	
11. BIRTHPLACE (State or foreign country) <i>Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jacob Woodring</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Calenier</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO. <i>131 Hazel Ave. Balto. 27</i>	
17. INFORMANT <i>Mrs. Grace Norris</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE <i>4221</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Recurrent Cerebral Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Generalized Arterial Disease</i>		DUE TO <i>Cardio Vascula Disease 5 years</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		DUE TO <i>Mercury Sepsis</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>White Not while at work</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Waynesboro</i>	
(County) <i>PA</i>		(State) <i>PA</i>	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____ and that death occurred at _____ M, from the causes and on the date stated above.		22b. DATE SIGNED <i>12/15/60</i>	
22a. SIGNATURE <i>John S. Key</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>John S. Key</i>		22d. ADDRESS <i>Odenton Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>Dec. 15 1960</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Burn Hill</i>		23d. LOCATION (City, town, or county) <i>Waynesboro Penna</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Walter J. Grover Waynesboro Penna</i>		25a. REC'D BY REGISTRAR <i>DEC 16 '60</i>	
ADDRESS <i>Walter J. Grover Waynesboro Penna</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13373

## CERTIFICATE OF DEATH

Reg. Dist. No.

13405

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ANNE ARUNDEL</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS, MARYLAND</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 ANAPOLIS, MARYLAND</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. NAVAL HOSPITAL, ANNAPOLIS, Md.</b>		d. STREET ADDRESS <b>56 MADISON PLACE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>BABY BOY 181</b>		First <b>ZIMMERMAN</b>	Middle <b>ZIMMERMAN</b>	Lost	4. DATE OF DEATH Month <b>DEC 31</b>	Day <b>1960</b>	Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-30-60</b>	9. AGE (In years lost birthday) yrs. <b>1 yr.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>DAVID LEE ZIMMERMAN</b>				14. MOTHER'S MAIDEN NAME <b>SHIRLEY MAY TAYBURN</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>U. S. NAVAL HOSPITAL ANNAPOLIS, MARYLAND</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>771.5 PREMATURITY</b>								
INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b>		DUE TO						
(c) <b>HEMORRHAGIC DISEASE OF THE NEWBORN</b>		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from <b>12-30, 1960</b> , to <b>12-31, 1960</b> , that I last saw the deceased alive on <b>12-31, 1960</b> , and that death occurred at <b>1050 P.M.</b> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>1050 P.M.</b>								
DATE SIGNED <b>1-1-61</b>								
ACTUAL SIGNATURE <b>J. John J. Mc Cann</b>								
PHYSICIAN'S NAME (Type) <b>LT JOHN J. MC CANN MC USNR</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-3-1961</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>U.S. Naval Academy Annapolis</b>		22d. LOCATION (City, town, or county) <b>Annapolis</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Mc Cann &amp; Sons Annapolis, Md.</b>		ADDRESS <b>2051181 XVA</b>		24a. REC'D BY REGISTRAR <b>JAN 5 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>		

